

Section III. Health-Related Behavior

Behavior Change

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Daniel O'Connell, PhD

INTRODUCTION

Despite the advances in medical technology that help physicians identify and treat problems from broken bones to rare bacterial infections, one aspect of treating patients defies neat categorization and clinical-manual roadmaps; that is, the behavior of patients—how patients react to illness, how they interact with their physicians, and how their attitudes and actions affect their health. Health-related problem behaviors can range from simply denying the fact of an illness to refusing either to discuss or to end smoking, drinking, or unhealthful eating. In dealing with such behaviors, physicians must be able to gauge the patient's readiness to change.

Development of the stages-of-change model discussed in this chapter was developed by Prochaska and DiClemente in the 1970s and can be applied to most of the health-related behaviors of concern found in primary care practice. The model posits that most people move through predictable stages in their efforts to change their health-related behaviors (Table 16-1). It provides a powerful framework for recognizing where patients are on a continuum of behavior change and how to influence their ultimate success.

ASSESSING STAGES OF CHANGE

In trying to modify patient behavior, it is essential to recognize the patient's readiness for and stage of change (see Chapter 21). For example, a 60-year-old widow whose drinking appears to be problematic might be asked whether she has noticed any problems arising from the consequences of her drinking. What has she tried to do so far about her alcohol use? To address a 25-year-old gay patient's risky sexual behavior, the clinician should ask specific questions to determine his present stage in thinking about and acting safely in sexual relationships: Does he recognize problems in his behavior? How could he reduce risks?

Is he already taking some action to reduce risks? Has he relapsed into riskier behavior after ending a long-term relationship in which safe sex was routine? The most valuable question for assessing the stage of change is "What thoughts have you had about [the problem behavior] and its effect on your health and life satisfaction?"

A key point to keep in mind is that stages of change are specific to each problem behavior: they are not global aspects of an individual's personality. For example, while a patient may be in the precontemplation stage for modifying his high-fat diet, he may already have moved through to maintenance on smoking cessation. Clinicians should also guard against the tendency to conclude prematurely that patients are completely ignoring or denying obvious problems.

For example, it is a common—but erroneous—belief that most problem drinkers and drug users are precontemplators, and that alcohol and drug addiction are diseases of denial. This concept assumes that the individual involved neither thinks about nor tries to modify the drinking or drug-use behavior. This situation is actually quite rare. It is common for problem drinkers to stop drinking hard liquor and switch to beer or wine in an effort to manage their drinking and its consequences. Although this approach is not likely to solve the drinking problem, such patients have clearly thought about (contemplated) the effects of various strengths of liquor. They have committed themselves to a different behavior (drinking wine or beer rather than hard liquor) and perhaps even achieved maintenance at this level.

Although many people do try to address their problems, they typically do not think their strategies through carefully enough, or they apply them inconsistently and without the skill to succeed. Astute clinicians will take note of such efforts at self-change and inquire about their effectiveness in ending the behavior—and its undesirable consequences—that prompted the effort to change in the first place.

Understanding the stages-of-change model gives

Table 16-1. Stages of change and patient characteristics.

Stage	Patient Characteristics
Precontemplation	The problem exists, but the patient minimizes or denies it.
Contemplation	The patient is thinking about the problem and the costs and benefits of continuing with the problem or trying to change.
Preparation	The patient commits to a time and plan for resolving the problem.
Action	The patient makes daily efforts to overcome the problem.
Maintenance	The patient has overcome the problem and remains vigilant to prevent backsliding.
Relapse	The patient has gone back to the problem behavior on a regular basis after a period of successful resolution.

clinicians a valuable tool for promoting behavior change. This is not an approach that encourages impassioned pleas, long exhortations, or ugly confrontations. Instead, clinicians are urged to focus on brief interventions that target specific obstacles to the patient's movement to the next stage (Table 16-2). The goal is to induct and maintain the patient in the change process until long-term success is achieved and, when possible, to shorten the amount of time required to accomplish a sustained behavior change.

Precontemplation

In this stage patients minimize or deny the existence of a problem behavior. Typically, the problem has been identified by others; patients try not to think about the problem and avoid listening to pertinent information and want others to do the same.

Patients are likely to deny the extent of the problem and its influence on themselves or others; they resist discussion of the problem, often with irritation, impatience, and defensive body language. Children and teens may claim to be bored by the topic. Adults may indicate that they are in a hurry, or that far more pressing concerns need their attention. In some form, "Get off my back!" is a common message from these patients.

It is important for clinicians to differentiate between true precontemplation and the reluctance to discuss uncomfortable issues that stems from other dynamics. The patient's reluctance to discuss the problem may reflect shame, demoralization, or a lack of trust in the clinician. Some patients are only too well aware of the problem and its costs to them and others (contemplation); they may feel overwhelmed by it and powerless to succeed in its resolution. They are often afraid of being embarrassed or shamed in front of the physician. In addition, whereas their resistance to discussion may appear to be precontemplation-stage behavior, some patients are actually demoralized long-term contemplators or relapsers. Although the clinician's interview style can influence the patient's willingness to discuss the problem, arguments, frustration, and antagonism on the part of both patient and clinician are highly likely.

Case illustration 1: Jack is 50 years old and is being seen by his internist. The appointment was made by Jack's wife Clara, ostensibly for follow-up of treatment

for persistent high blood pressure. The actual reason, as explained to the nurse-receptionist, is Clara's concern about her husband's drinking and his failure to follow the clinician's latest recommendations for blood pressure control. During the appointment, Jack does not mention any problems with alcohol or any difficulty following the recommended regimen. When the doctor presses Jack for more details about the amount of alcohol he is consuming, Jack becomes evasive and irritated. The physician backs off and ends the visit with only a change in medication—and a feeling of frustration.

To avoid this impasse, the physician should express curiosity about Jack's own thoughts and feelings about his use of alcohol and its possible effect on his health. Pressing for details about problem behaviors often provokes defensiveness in precontemplators who quickly suspect that they are being trapped through interrogation. The physician's goal is to promote the patient's own willingness to contemplate potential health problems related to his behavior.

Clinicians often believe that their practices are overrun with patients in the precontemplation stage. As they listen more carefully to their patients' thoughts about such behavior, however, they often find that many of the patients are already wondering about the problem and how to resolve it. The psychology theory of reactance posits that individuals are strongly motivated to maintain a sense of autonomy and to resist coercion by others. Because people resolutely protest and resist the perception that another's will is being imposed on them, the best way to influence patients' behavior is to create the perception that the change was their idea in the first place. Reactance creates its own logic, and patients who might otherwise have admitted their concern over a problem may instead feel compelled to defend their behavior.

At some point the precontemplator may begin to think about the problem and how it might be solved. This movement could be prompted by threats from others, developmental pressures (eg, "Now that I'm a father, I don't feel as much like partying"), a compelling example in real life or fiction, or a skillful interaction that makes the person aware of the negative consequences of the behavior without increasing defensiveness. The patient can then move into the contemplation stage of change.

Table 16-2. Stages of change and clinician strategies.

Stage of Change	Patient Characteristics	Clinician Strategies
Precontemplation	Denies problem and its importance. Is reluctant to discuss problem. Problem is identified by others. Shows reactance when pressured. High risk of argument.	Ask permission to discuss problem. Inquire about patient's thoughts. Gently point out discrepancies. Express concern. Ask patient to think, talk, or read about situation between visits.
Contemplation	Shows openness to talk, read, and think about problem. Weighs pros and cons. Dabbles in action. Can be obsessive about problem and can prolong stage.	Elicit patient's perspective first. Help identify pros and cons of change. Ask what would promote commitment. Suggest trials.
Preparation/ Determination	Understands that change is needed. Begins to form commitment to specific goals, methods, and timetables. Can picture overcoming obstacles. May procrastinate about setting start date for change.	Summarize patient's reasons for change. Negotiate a start date to begin some or all change activities. Encourage to announce publicly. Arrange a follow-up contact at or shortly after start date.
Action	Follows a plan of regular activity to change problem. Can describe plan in detail (unlike dabbling in action of contemplator). Shows commitment in facing obstacles. Resists slips. Is particularly vulnerable to abandoning effort impulsively.	Show interest in specifics of plan. Discuss difference between slip and relapse. Help anticipate how to handle a slip. Support and reemphasize pros of changing. Help to modify action plan if aspects are not working well. Arrange follow-up contact for support.
Maintenance	Has accomplished change or improvement through focused action. Has varying levels of awareness regarding importance of long-term vigilance. May already be losing ground through slips or wavering commitment. Has feelings about how much the change has actually improved life. May be developing lifestyle that precludes relapse into former problem.	Show support and admiration. Inquire about feelings and expectations and how well they were met. Ask about slips, any signs of wavering commitment. Help create plan for intensifying activity should slips occur. Support lifestyle and personal redefinition that reduce risk of relapse. Reflect on the long-term—and possibly permanent—nature of this stage as opposed to the more immediate gratification of initial success.
Relapse	Consistent return to problem behavior after period of resolution. Begins as slips that are not effectively resisted. May have cycled back to precontemplation, contemplation, or determination stages. Lessening time spent in this stage is a key to making greater progress toward fully integrated, successful, long-term change.	Frame relapse as a learning opportunity in preparation for next action stage. Ask about specifics of change and relapse. Remind patient that contemplation work is still valid (reasons for changing). Use "when," rather than "if," in describing next change attempt. Normalize relapse as the common experience on the path to successful long-term change.

Contemplation

In this stage the patient is thinking about the problem and potential solutions, weighing the pros and cons of each scenario, and showing behaviors characteristic of contemplation.

- The patient is open to thinking about and discussing the problem.
- The patient appears interested, may ask for additional information, or try to explain why the problem has persisted.
- The patient weighs the pros and cons of changing or not changing the problem behavior.
- Unless the patient is pushed to make a specific

commitment to take appropriate action, there is less risk of irritation and argument.

- The contemplation stage can be prolonged or obsessive. Patients who have been in contemplation for a long time often request more convincing data and look for the ideal time and situation in which to initiate change.
- Patients may seem to be dabbling in action without a commitment to overcome obstacles that arise. They may, for example, decline an occasional dessert, not drink on weekdays, or make early-morning promises to change—and break them by midafternoon.

- Contemplators may view obstacles from too limited a framework, for example, doubting that they have sufficient "will-power" to follow through.

Some contemplation behavior appears to be necessary for later successful resolution of the problem. Patients must anticipate costs and obstacles, identify their motivations, understand how easy or difficult the behavior change might be, and feel that they are making informed and independent decisions, rather than being coerced by others. Although some people claim that they impulsively threw away their cigarettes, or that they quit drinking and never once looked back, research suggests that even these people may have been quietly doing contemplation work in the years and months leading up to the presumably impulsive action.

Case illustration 2: Joanna is 44 years old and has been smoking a pack of cigarettes a day since she was 17. When prompted by her family practice clinician she is very willing to discuss the pros and cons of smoking. Joanna tells her doctor that she is being pressured by her children about secondary smoke and that she agrees with their position. She thinks that the habit is both expensive and stupid. On the other hand, she believes that smoking is one of the few things that relax her throughout the day at work and at home. One of her friends quit smoking and gained 25 pounds; this possibility is frightening to Joanna, who is already concerned about her weight. She wonders whether medication or a nicotine patch or gum would make quitting easier and perhaps keep her from gaining weight. She has often promised herself in the morning that she would cut down drastically on cigarettes but has lost her resolve with her coffee break. She wonders aloud whether there is any better or worse time to try to quit. By the end of the discussion, Joanna has promised her doctor to think even more seriously about quitting.

Often the physician can help the contemplator move toward being more determined to change simply by eliciting the pros and cons the patient has been weighing as he or she thinks about trying to change. In this case, the doctor's empathic summary brings the contemplator's dilemma into clearer focus:

DOCTOR: It sounds as though you realize that changing your behavior—not smoking—will be best for you in the long term, but you're still trying to anticipate your short-term sacrifices and need to decide how you'll cope with them.

Following a period of contemplation—which can be a few days or several years—many people move toward a greater resolve and sense of urgency about changing the problem behavior. There may be a convergence of information and threat or pressure (eg, the alcoholic husband whose wife threatens divorce, the smoker who learns she is pregnant), an inspiring model, the chance for increased social support with others undergoing similar changes, or opportunity for

a fresh start, such as a job transfer or move. Such changes leads to the preparation/determination stage.

Preparation/Determination

In this stage the patient experiences a mounting sense of urgency and commitment to change.

- The patient talks about having made the decision to change, in contrast with the contemplator's desire or hope to change.
- The patient has committed to a specific goal: "I am going to stop smoking completely." "I will exercise three times a week."
- The patient mentions a specific time to begin the activity: "On my next birthday. . . ." "After my surgery. . . ." "When the kids start school in September. . . ."
- The patient has chosen a specific course of action, such as joining a commercial weight-loss program or Alcoholics or Narcotics Anonymous (AA, NA), or is asking for a referral so the health plan will cover the treatment.
- The patient is willing to pay the costs of change, including out-of-pocket expenses, the time required for the change, physical discomfort, embarrassment, and public exposure.
- The patient considers the potential reactions of important people who may resist or be threatened by the change. A spouse or partner who smokes or drinks or is overweight, for example, may react negatively to the patient's plans to overcome the problem. Sometimes this occurs because such individuals anticipate pressure to face their own problems. In other cases, spouses, partners, and friends may resist the patient's decision to change because of some anticipated personal inconvenience (eg, the husband who must watch the children while his wife goes to an aerobics class) or embarrassment over the possibility of exposing a weakness to friends or neighbors.
- The patient can envision overcoming obstacles that lie ahead and how to overcome them.

Case illustration 3: Mike is a 15-year-old boy who has been doing poorly in school for several years. Although he has been diagnosed with attention deficit hyperactivity disorder, his parents, teachers, and pediatrician has been unable to convince him to take his medication regularly. Now he has asked for an appointment with his pediatrician to discuss the situation. During the visit, Mike confesses that he is tired of his problem behavior and poor school performance. Further questioning by the physician reveals that one of Mike's friends admitted being treated for attention deficit hyperactivity disorder. Mike noticed and envied his friend's success; he asks the physician to prescribe "whatever it will take to get me out of this."

The pediatrician probes a bit to establish that Mike has thought through the pros and cons of taking stimulant medicine and that his parents are still committed to

such a plan. The parents are invited into the examining room, and all agree on a plan that will begin with a trial of stimulant medicine. The effects of the medication will be reassessed in a month, based on questionnaires filled out by Mike and his parents and teachers.

By allowing Mike to work through the contemplation stage at his own pace, the pediatrician has helped establish an informal commitment to a treatment plan. He is treating Mike as a young person who can understand and assimilate information and who is capable of weighing the costs and benefits of treatment and then committing himself to the plan.

The day finally arrives when the individual begins to put the chosen plan into action. Some people may move back and forth between determination and contemplation a few times without going on to take action against the problem. They may feel—and claim to others—that a major effort at change is imminent, only to back off to the contemplator's lower level of urgency. The clinician can help patients at the determination stage intensify their commitment to a specific course of action (see discussion under "Promoting Behavior Change"). Patients at this point may talk about "gearing up" for action—the next stage.

Action

In the action stage, patients follow specific activities intended to achieve the goals they have set. While the patient's goal—cutting down on drug use, for example, rather than quitting completely—may not be exactly what the clinician prefers, the patient believes it is worthwhile and achievable on the basis of the previous period of contemplation.

- The patient has begun a set of actions intended to solve the problem. He or she has joined and is attending a weight-reduction group; has started going to AA and cut down or stopped drinking in the last few weeks; has recently quit or cut down on smoking and may be wearing a nicotine patch; or is exercising regularly.
- The patient may be focusing on one day at a time or trying to look past the initial discomfort by focusing on the long term.
- The patient recognizes and deals with the obstacles that arise before they can derail the program. The work done previously in the contemplation and preparation/determination stages is evident in the patient's comments during discussions with the clinician.
- Unlike the contemplator, the action patient does not allow exceptions to the course of action. This is not experimental dabbling in change to see what it might be like. At this stage, the patient has already decided that the discomfort of changing will be worthwhile. It remains to be seen whether the actual experience will be more difficult than was ex-

pected and whether the action plan can be maintained.

- By keeping the motivation for change in mind, the patient reinforces his or her commitment.

This is a time of maximum focus and effort. The greatest risk is that second thoughts may plague the patient, who is now particularly vulnerable to abandoning the change effort in a moment of weakness. Unexpected discomfort, resistance from others, or temptations that were neither anticipated nor planned for may overwhelm the patient's commitment to change. The action plan may then be abandoned precipitously.

Case illustration 4: Martha is a 45-year-old diabetic patient of a family practice. Over the last few years, her doctor has encouraged her to lose weight and exercise regularly, without much success. Martha comes in today and proudly reports that she has joined a weight-loss group that is held at her work site. Two colleagues have also joined, and they all have been attending faithfully and following the dietary recommendations for the last 3 weeks. The doctor encourages Martha to talk about her efforts. She is eager to talk; she reports feeling a great sense of pride and satisfaction. She admits that although she had been disgusted with herself for getting so heavy, she never before felt ready and able to tackle the problem. When her friends suggested that they join the group together, she was surprised at her enthusiastic response. She understands that this is the situation she had been hoping for, one that could provide support in making a difficult change.

Martha also admits to anxiety, since many people now know that she is trying to lose weight, and she does not want to fail publicly. Although she has been tempted to cheat on the diet, she has resisted the urge. She tells the doctor that she had felt somewhat discouraged when she did not lose as much weight as she had hoped the previous week. She asks the doctor to look over the program's dietary recommendations to be sure that they are safe in light of her diabetes.

After checking the weight-loss program's recommendations, Martha's doctor encourages her to discuss both the action steps she is taking and the reasoning (the contemplation work) that led to the effort. By asking open-ended questions about what Martha is doing and how the effort is going, the clinician reinforces the effort at change. Given enough time during the visit, he can make additional helpful suggestions to reduce the risk of early relapse and orient Martha more firmly toward long-term maintenance. The clinician's warm, curious, and engaged demeanor has reverberations beyond the visit. Martha can use the pleasant memory of the encounter to further internalize the value of the effort toward change.

The action stage is a time of concerted effort to resolve the problem. Once change has begun, however, many individuals are surprised to find that their resolution has faded, and all the ground gained during the action stage can be lost in relapse. Long-term vigi-

lance and occasional (or even frequent and prolonged) supportive activity are necessary to prevent backsliding into a full relapse. This period of sustained vigilance and activity is known as the maintenance stage of change. For people who must control their weight, this stage may last a lifetime. In one study, former smokers reported some temptation to smoke 18 months after quitting. Problem drinkers may continue in AA for many years before they feel comfortable that their risk of relapse is low. Clinicians should be concerned about patients who have made good progress on resolving health-behavior problems but cannot describe their long-term plans to prevent relapse. Helping patients anticipate and find answers to the questions addressed in the next section is an important way in which clinicians can promote success at this stage.

Maintenance

The maintenance stage is the period of sustained vigilance and activity needed to preserve the improvements achieved during the action stage.

- The patient has achieved a period of success—as he or she has defined it—in overcoming the problem. The patient may have cut down or stopped drinking, reduced to the desired weight, or gone without cigarettes for several months. He or she is managing time and commitments better so that stress is no longer overwhelming, has gained consistent control over a short temper, or has accomplished any other desired outcome.
- Some patients assume a positive identity, seeing themselves as people who have overcome a problem and who are able to continue the action for a protracted period to prevent relapse. Patients who begin an exercise and diet program in order to lose weight, for example, may become avid hikers whose leisure time is devoted to rigorous outdoor adventures. These people have made a life-style and identity change in which the former problem behavior has no place.

To continue this period successfully, the patient must be able to handle both predictable and unpredictable obstacles and accept the constraints of abstinence. This requires dealing appropriately with the temptations and frustrations that inevitably arise in the months and years following successful action.

- Some patients may be frustrated that success in dealing with one problem has not brought about hoped-for changes in other areas. For example, while the weight loss may produce a slimmer, healthier body, it does not necessarily lead to an idealized slenderness and attractiveness. Abstinence from crack cocaine may not be enough to end all marital, job, and financial problems.

Patients who reduce their workaholic schedules so as to spend more time with their families may find they've traded more admiration at home for less at work. They must first take satisfaction in accomplishing their stated goals and then be ready to go to work on other dissatisfactions.

- The initial intensity of effort may be tapering off. Attendance at support-group meetings, for example, may have become erratic. The patient may be wondering whether it is now safe to quit the group or treatment program or to end a diet. It is hard to know when one is "out of the woods" and the problem resolved; successful maintenance requires both accurate self-appraisal and ongoing vigilance.
- Slips into the problem behavior may begin to be tolerated or justified: "I'll have just one glass of wine when I'm out with friends." "I'll only have a cigarette if I'm feeling really tense." These seductive thoughts must be resisted if successful maintenance is to continue; it may be necessary to renew the intense efforts of the action stage to do so.

Case illustration 5: At 55 years of age, Bill is—overall—doing very well, seeing his internist, periodically for health maintenance. Bill had been a very heavy drinker for 20 years; 5 years ago, a citation for driving under the influence of alcohol and the threat of divorce by his second wife pushed him into an alcohol treatment program. He achieved abstinence while attending the formal, court-mandated, 2-year outpatient treatment program. Since that time he has continued in AA, attending at least two meetings a week and occasional weekend conferences and workshops. Bill also sponsors a younger man in the group. In his conversations with his doctor, Bill describes himself as a recovering alcoholic. He schedules an appointment to discuss his distress over problems his son is experiencing—for which he holds himself partly responsible. The doctor thinks antidepressant medicine might be helpful, particularly in light of Bill's disturbed sleep and preoccupied demeanor. Bill questions the internist closely about the risk of addiction and explains his reluctance to use "another crutch" to control his moods.

Bill's doctor can be helpful here by recognizing that because Bill is consciously in maintenance he is extremely vigilant about anything he sees as a threat to his sobriety. The doctor asks directly and respectfully why Bill believes antidepressant medication might undermine his sobriety or stimulate a new addiction. Bill says that he is basically afraid of becoming dependent on the medication. The physician advises him to think about the recommendation and to speak with other AA members or friends. He also suggests that Bill read some related articles before his follow-up appointment so that he can make an informed commitment to addressing the depression through psychotherapy or a self-help group or by taking the prescribed medication.

Unfortunately, the odds favor relapse over any other outcome for a single attempt at health-behavior

change. Clinicians know from both research and experience that too often patients' attempts to lose weight, stop alcohol or drug abuse, change their lifestyles to reduce stress, alter their diets in a more healthful direction, and even to floss their teeth daily are most likely to end in relapse. The false starts, failed promises, and pounds lost and promptly regained tend to obscure the reality that persistent effort often does result in successful resolution of the problem. Although any single effort to change is likely to get derailed before the patient achieves successful long-term maintenance, repeated efforts tend to yield the desired result eventually (this is borne out by Schacter's classic 1982 study). It is worth noting that more than 40 million Americans have quit smoking, many on their third or fourth serious try.

Many patients who appear to have reached the maintenance stage—for however brief a time—relapse, reverting to the undesirable behavior. Using the stages-of-change model, clinicians can encourage patients to keep working at the process of change, learning from each stage and experience, until the patient finally manages to reach—and maintain—the desired outcome.

Relapse

All relapse begins with a "slip," a deviation from the action plan. In a slip, the patient has an episode of problem behavior after a period of self-defined success in having overcome the problem. A slip might constitute engaging in an undesirable behavior such as smoking, or not engaging in a desirable behavior such as exercising. In the actual relapse stage, patients return to consistent problem behavior. With prompting by the clinician, patients may be able to describe the circumstances that led to the slips and eventually to relapse. They can learn how to anticipate and correct these vulnerabilities when they take action again.

- The typical patient in relapse has regained the weight lost, has begun drinking heavily again, has started smoking cigarettes after a period of nonsmoking during pregnancy, or has stopped using condoms during sexual intercourse with new partners.
- The patient may now talk or act like a person in an earlier stage of change. He or she may have entered a period of resistance and avoidance that is characteristic of the precontemplation stage. Alternatively, the patient may be contemplating change again, possibly even considering action in the near future.
- Relapsing patients' stories are more complex than those of patients who have never relapsed or are in earlier stages, and the reasons offered for the relapse provide many clues to the steps that must be taken to reinvigorate the patient's willingness to tackle the problem again. One patient may think: "I did it once, I can do it again!" Another patient may instead think: "I guess I don't have the willpower to do this."

The time the patient spends in relapse before initiating the next action stage of change accounts for much of the observed slowness in achieving final success for many health-behavior problems. Relapse is the norm for any single attempt at change. Even in professional treatment, as many as two thirds of the participants are likely to have relapsed within a year after achieving initial alcohol or drug sobriety. Success in smoking cessation, weight control, or alcohol and drug sobriety is usually achieved after a number of separate, unsuccessful attempts at change. In one study of smoking cessation, it took an average of 7 years to move from precontemplation to maintenance of smoking cessation. The typical participant had three relapses during that period, in which he or she had resumed regular smoking.

If handled empathically, patients in this stage are usually not too entrenched in denial or resistance. They had already concluded at least once that change was needed and can often recount the costs of continuing the problem behavior. It is the uneasiness they feel in anticipation of trying again to change that often has them stuck. Knowing this, the clinician can save much time that might otherwise be wasted on lecturing patients about things they already know and with which they agree.

Case illustration 6: Barbara is a 28-year-old woman who is being seen 2 months after the birth of her second child for renewal of her birth control prescription. Her physician is delighted to see Barbara again. As the interview evolves, Barbara sheepishly reveals that she is back to smoking a pack of cigarettes a day. The clinician is both disappointed and surprised, since Barbara had been quite proud of the fact that she stopped smoking during the pregnancy. The doctor takes a deep breath and calmly asks Barbara how that could have happened so quickly. Barbara talks about how frazzled she has felt taking care of both her baby and her 3-year-old son. She explains how, at first, she found it relaxing to smoke a cigarette or two after dinner with her husband (who is also a smoker); she had not pictured herself smoking a pack a day again. Soon, however, she was smoking with a friend who stopped in to visit. Now she has begun looking forward to a cigarette whenever she has a break from the immediate demands of her family. She tells her doctor that although she tries never to smoke when the baby is up, even this control is starting to erode.

The doctor's first challenge is to manage her own frustration and not leave Barbara feeling judged and ashamed. She points out Barbara's success in caring for her (then) 2-year-old child and dealing with the mood swings and physical discomforts of pregnancy without smoking. She also expresses her support and encouragement for the Barbara's recommitment to abstinence. Reaffirming the health benefits of not smoking—for both the patient and her children—helps reinforce the commitment. As a further step, the clinician suggests making and enforcing a no-smoking rule in the house.

PROMOTING BEHAVIOR CHANGE

The clinician's first task is to identify the patient's stage of change for each behavior of concern. The more accurately the clinician can differentiate the stages, the easier it will be to make a brief—but effective—intervention during a regular medical visit.

The clinician's main task is to promote movement from one stage to the next. Clinicians who are aware of the theory of reactance avoid forcing change on patients out of their own sense of urgency. Forgetting that most people strive to be self-directed and resist coercion only frustrates the clinician and impairs the doctor-patient relationship, which over time is a key to exerting influence. Shame or embarrassment might lead the patient to avoid facing the clinician again. Clinicians must also remember that they are neither powerless nor all-powerful. Addressing only the aspects of the present situation that hinder movement to the next stage makes the best use of primary care clinicians' time and energy to help change behavior.

Because behavior change is an area of practice that many clinicians find frustrating, it is important to guard against feeling either irritation or apathy. By reflecting on their own attempts at change, clinicians can better appreciate the time, false starts, and circular nature of the change process. This makes it easier to feel and express empathy to patients for their difficulties along the path to changing patterned behavior. Research has consistently demonstrated the power of an empathic and involved supporter in promoting growth and change.

It also helps to adopt an attitude of curiosity whenever patients behave in ways that seem illogical or counterproductive. Dismissing such behavior as stupidity, dependency, irresponsibility, or the manifestation of a personality disorder can block a more helpful line of inquiry. The clinician can instead ponder why this patient waited weeks for an appointment, sat in the reception area for an additional half hour because the doctor was running late, paid for some or all of the cost of the visit, felt physically and emotionally uncomfortable enough about a problem to discuss it, and then didn't follow through on the recommendations that were made to resolve or ameliorate it. The clinician can express that curiosity to the patient, saying, for example, "I'm curious as to why you think you couldn't start the exercise program we discussed at your last visit. What do you think is the most important thing you must do to get that exercise program into your regular schedule?" The most productive questions are those that convey a respectful curiosity and that focus the patient on identifying and overcoming specific obstacles to change.

Success entails helping patients view themselves as engaged in an ongoing process of changing the specific behavior, and the clinician can help make that the most efficient process possible. If the average patient (as reported in one study) takes 7 years to move from

precontemplation to maintenance, cutting that time to 4 years through skillful intervention is a significant improvement. Understanding the length of time required to make such changes can relieve clinicians of the urgency and pressure that come with unrealistic goals.

Strategies for the Precontemplation Stage

The clinician should ask pertinent questions before attempting to persuade patients to change their behavior, for example, "What effect do you think your smoking has on your asthma?" Questions of this kind, asking patients to *contemplate* the possible connections between the physical symptoms that bother them and the behaviors that may be provoking those symptoms, are among the most helpful to precontemplators.

Patient defensiveness can often be defused if practitioners ask the precontemplator's permission before talking about the problem, for instance, "Would it be all right if we talk a little more about how your drinking might be contributing to some of the problems you mentioned today?" The physician's agenda should be linked with concerns the patient has already expressed. If a female patient asks for birth control, the clinician can use her concern about pregnancy as a basis for asking how else she had previously been protecting herself when having sex. Patients who complain about headaches can be asked what is going on in their lives that could affect the headaches. This is a way of examining patients' life stresses by placing them in a natural context and so avoiding the patients' suspicion that the physician is dismissing the problem as "all in your head."

Discrepancies between the patient's present behavior and the expressed goal of feeling better and worrying less should be pointed out gently. Physicians should also express their concern that the patient may not achieve the desired improvement without addressing the specific problem:

DOCTOR: I'm concerned that you'll always worry about another heart attack unless you know you've changed your life-style and lowered the risk.

I'm concerned that none of these medicines will be able to relieve your stomach discomfort as long as you drink alcohol and caffeine.

The goal with precontemplators is to increase their willingness to understand (contemplate) the connections between behavioral health and physical health as the first step toward change. Much of the actual contemplation work is done between visits, and clinicians can ask whether the patient is willing to think about, keep track of, and read about the problem and potential solutions—or talk to someone else about them—before the next appointment. The clinician should be sure to note the patient's response and mention it at the next visit.

Strategies for the Contemplation Stage

In this stage also, the clinician should elicit the patient's perspective before offering advice, with questions that acknowledge movement toward change:

DOCTOR: What have you been thinking about your cigarette smoking and what you might be able to do about it?

Patients can be helped to identify the pros and cons of change and to examine the current pleasures and ultimate consequences of the problem behavior, as well as the anticipated consequences of trying to change it. It seems axiomatic that people do unhealthy things because they desire the pleasures such acts bring. Many patients already believe that they would be better off if they ate differently, exercised more, drank less, stopped or cut down on drug use, lost weight, reduced stress, and so on. Contemplators frequently become stuck in ambivalence over the possibility that the change process itself will be psychologically or physically unpleasant, costly, and likely to fail; they may need help identifying and working their way through these anticipated obstacles. Clinicians can ask the patient what the greatest obstacle has been in taking action to resolve or ameliorate the problem and focus their curiosity on this obstacle.

Patients who claim that—because of insufficient will power—they are powerless to stop smoking, quit drug or alcohol abuse, or change any other behavior should be asked such questions as, "If you were convinced that your wife's life depended on your not smoking for 3 months, do you think you could resist temptation that long? Where would the ability to do it come from?"

Similarly, patients should be asked what they think would bring about a commitment to change the behavior:

DOCTOR: If I were to meet you years from now and find that you had completely stopped using crack cocaine, what do you think you would tell me was the reason you finally decided to stop?

Depending on the answer, the next questions might be,

DOCTOR: Knowing that such an event (eg, arrest) is likely to come about, what do think about trying to resolve the problem before that happens?

What approach do you think you would use to overcome the problems if you believed you really had to?

What obstacles would you encounter if you were to start using that approach now?

Clinicians can encourage patients to think about an upcoming time in which taking action to resolve or improve the problem situation would be least taxing.

Suggestions for limited trials of possible solutions might include the following questions:

DOCTOR: Would you be willing to cut down from 20 to 15 cigarettes a day and make a note of how hard or easy this is for you?

I know you want to resolve the argument you and your wife are having about how much you actually drink. Would you be willing to write down in a notebook every alcoholic drink you have for the next 2 weeks?

Even when the patient objects to this strategy as being unrealistic, the suggestion raises the possibility that such data can help answer previously unresolvable questions and arguments.

DOCTOR: Would you be willing to always carry a condom with you so that it's available the next time you have intercourse?

Before our next appointment, would you be willing to check with your health plan about your options for getting alcohol treatment in the evening? That way, if you should decide to start treatment, you wouldn't miss work and no one there would have to know about the problem.

Strategies for the Preparation/ Determination Stage

Patients should be encouraged to set a date to start action on the problem. They should be helped to understand more clearly the program they are planning to follow, including structured activities or referrals. Summaries can be used for clarification:

DOCTOR: So you're planning to start Weight Watchers at work next month with the goal of losing 35 pounds?

You've committed yourself to getting 30 minutes of aerobic exercise four times a week.

These comments should be noted in the chart in the patient's presence, and the patient should be told that the clinician is looking forward to hearing about what happens next.

Patients should be supported with reassurance that initiating action to change problem behavior is always the right thing to try. Even when the attempt is not fully successful, the experience will yield helpful information about how to succeed eventually. It is important not to appear so enthusiastic, confident, and hopeful that patients who are unsuccessful in taking the agreed-on step feel too ashamed to see their physicians that they avoid them. Because public commitments are more likely to be kept than private ones, patients should be encouraged to tell others about their commitment to change.

Follow-up is also important, whether it involves scheduling an appointment, sending a postcard, or requesting a note or phone message soon after the proposed start date. Clinicians should highlight the patient's commitment as being an important step be-

yond prior contemplation and thus deserving of special attention.

Strategies for the Action Stage

A warm inquiry about the specifics of the patient's activities to promote change adds the support and encouragement of a professional person to the patient's other social supports. Clinicians should also ask about any obstacles the patients encounter (obstacles and second thoughts are to be expected) and how they are handling the problems. The clinician can suggest that patients write out the pros of making the change and post them prominently as an aid to maintaining their motivation. An accepting attitude encourages patients to try problem solving rather than yield to the urge to give up.

Patients should be asked for permission to consult with any other professionals involved in the program. A brief contact with a chemical-dependency counselor, smoking-cessation group leader, psychotherapist, and so on demonstrates that the physician values and supports the patient's efforts during the most vulnerable period of active change.

It is important to help patients prepare for recovery from slips—smoking a cigarette, having a drink, missing an exercise session or AA meeting, or having seconds at a meal. A slip need not become a fall if patients have anticipated the possibility and prepared how they will think about the slip and react once it is recognized: throw out the rest of the cigarette pack; pour out the remainder of the bottle; add another exercise session or AA meeting; eat a smaller-than-usual portion at the next meal; and reaffirm the commitment to conquer this problem.

Some type of follow-up (eg, a note, a call, an appointment) should be scheduled both to get a progress update and to show support for the patient. Physicians can give patients preaddressed postcards and ask them to write brief notes on their progress 2 or 4 weeks into a new change effort. A telephone call from the office nurse can reassure the patient and provide a progress report. Making a note on the chart will remind the physician and office staff to inquire about the change effort at the next patient contact.

Strategies for the Maintenance Stage

Inquiring about how well the patient is maintaining the improvements achieved in the action stage is an important first step:

DOCTOR: What have you been doing to keep your weight down?

Have you been going to your support-group meetings regularly?

How well have you been doing with your exercise program?

Successful maintenance often involves making lifestyle changes that turn out to have significant positive

effects beyond control of the original problem. The sedentary patient who starts a program of physical activity for cardiovascular conditioning may find, as a bonus, both long-term weight control and unexpected skill on the tennis court. In addition, clinicians who have successfully stopped smoking, lost weight, or become more physically active can sometimes use themselves as examples of the real possibility of maintaining change. The key here is to emphasize that the new behavior can become an integral part of a more healthful and satisfying life-style.

Patients should be asked about slips that have already occurred and how they responded. Even when patients say that they have stopped drinking or smoking, it makes a great deal of sense to ask neutrally, "Have you had even one drink (or cigarette) since you quit?" Many quitters have at least one slip to report, and discussing how a full relapse was prevented can reinforce their commitment and identify risky situations.

It is important to emphasize the difference between a slip and a full relapse. Because many patients do not even want to consider making a slip, they may be unprepared to react appropriately if it occurs. Patients should be prepared for the likelihood of a slip and have a plan for how to deal with it at once. They may protest that the clinician is being too pessimistic; explaining to patients that such preparation is a way of protecting their newly achieved change can provide a more positive tone.

Patients should also be asked what they have learned so far about the change process as well as how confident they are that they will maintain the improvement over the next time period. They should further be asked to describe their highest-risk situations for a slip or relapse—an event such as a party, or an emotion such as anger, sadness, or exuberance—and how prepared they feel to handle these high-risk situations without a slip.

Each of these recommendations involves showing interest, support, and curiosity and suggesting that anticipation and vigilance are the keys to successful maintenance.

Clinicians must be alert for any signs of waning enthusiasm and express their curiosity about the cause. As noted earlier, patients often become discouraged when improvement in one area does not resolve other life dissatisfactions. They may feel that others do not recognize and appreciate the effort that they have made to change. A sincere compliment from a clinician accompanied by a message that "I am rooting for you" creates a memory that can be recalled during moments of discouragement.

Strategies for the Relapse Stage

The key to dealing with relapse is to reframe it as a valuable learning experience that will shed light on how best to go about the next attempt at change. It is therefore essential that clinicians express their interest in the last attempt at change and ask the patient to de-

scribe exactly how initial success was achieved and how slips led to a full-blown relapse.

Some patients promptly—and erroneously—conclude, “I tried it and it didn’t work; therefore, it never will work.” This is too global a statement; it obscures the successful components that could be used in the next change effort. The physician’s response might be:

DOCTOR: It sounds as though you were very successful in quitting smoking using the action strategies you described, and they might work well again. Where you fell down was in thinking that you could have one cigarette and not recognizing how dangerous this could be for you.

The next attempt at change should be discussed as inevitable—*when* rather than *if*. Patients should be reminded that all the analysis and conclusions that led to deciding to change last time remain valid. If chang-

ing was the right decision then, it is still the right decision now. The question the relapser must answer is “What is the next step for you to get moving again toward change?”

Clinicians should remember that many patients think of themselves as relapsers, even if the care and commitment they put into previous attempts at change seem inadequate. The relapser may feel more demoralized than makes sense since from our point of view a good deal of constructive work must have been done leading up to the failed effort to maintain the desired change. One of the most helpful aspects of using the stages-of-change model is the optimism it generates for both clinician and patient. The concept that pursuing the process knowledgeably and persistently over time almost inevitably brings about the desired change is a welcome counter to the frustration and pessimism so often reported by clinicians and patients alike.

SUGGESTED READINGS

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5

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Principles of Motivational Interviewing

If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.

—Johann Wolfgang von Goethe

The original concept of motivational interviewing grew out of a series of discussions with a group of Norwegian psychologists at the Hjeltestad Clinic near Bergen. They asked one of us (Miller) to demonstrate how he would respond to particular problematic situations they were encountering in treating people with alcohol problems. As he demonstrated possible approaches, they asked excellent questions: "Why did you say that instead of something else? What were you thinking when you said that? Why did you remain silent? What is it that you are trying to *do* with the client? Why didn't you push harder at that point? Where are you going with this line of *u* *s*? Why didn't you just tell him what he should do?" The result was a *rs*. *ement* of principles and strategies of motivational interviewing (Miller, 1983).

In the ensuing years, much progress has been made toward clarifying and specifying processes of motivational interviewing. Important clinical applications have been undertaken in Australia, Britain, Canada, The Netherlands, Scandinavia, and the United States, and some of these are reflected in Part III of this book. A number of evaluations of motivational counseling strategies have been completed (as reported in Part I), and others are underway.

From its beginning, motivational interviewing has been *practical* in focus. The concept arose from the practical questions of clinicians. Its principles have emerged from our own experience in working with hundreds of people with alcohol and other problems, and in this sense it has been taught to us by our clients. It has been enthusiastically adopted by clinicians

in a broad range of cultures because—they tell us—of its applicability and practical utility.

But what is motivational interviewing? We begin this chapter by providing a statement of what we perceive motivational interviewing to be, and how it differs from other approaches. Then we proceed to outline five key principles of this approach.

What Is Motivational Interviewing?

Motivational interviewing is a particular way to help people recognize and do something about their present or potential problems. It is particularly useful with people who are reluctant to change and ambivalent about changing. It is intended to help resolve ambivalence and to get a person moving along the path to change. For some people, this is all they really need. Once they are unstuck, no longer immobilized by conflicting motivations, they have the skills and resources they need in order to make a lasting change. All they need is a relatively brief motivational boost (see Chapter 3). For others, motivational interviewing is only a prelude to treatment (though an important one). It creates an openness to change, which paves the way for further important therapeutic work.

In motivational interviewing, the counselor does not assume an authoritarian role. One avoids the message that "I'm the expert and I'm going to tell you how you need to run your life." Responsibility for change is left with the individual (which, by the way, is where we think it *must* lie, no matter how much therapists may debate about what we can "make" or "allow" or "permit" our clients to do). Our clients are always free to take our advice or not. This certainly does not mean that therapists are helpless or powerless. To the contrary, some research indicates that therapists exert a surprising amount of influence over whether or not their clients change!

The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The counselor seeks to create a positive atmosphere that is conducive to change. The overall goal is to increase the client's intrinsic motivation, so that change arises from within rather than being imposed from without. When this approach is done properly, it is the client who presents the arguments for change, rather than the therapist. Motivational interviewing employs a variety of strategies, some of them derived from client-centered counseling, to accomplish this. In contrast to more aggressive styles, the counselor may at times appear relatively inactive. Yet the motivational interviewer proceeds with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments.

Differences from Three Other Styles

Confrontation-of-Denial Approaches

In Part I we have described how motivational interviewing differs from traditional strategies that are predicated on the assumption of "confronting denial." These contrasts have already been discussed in detail, but it may be useful to summarize these points here. A list of contrast points is provided in Table 5.1.

Skill-Training Approaches

A second general counseling orientation with which motivational interviewing can be contrasted is a directive approach that emphasizes skill training. The term most often used for this approach is "cognitive-behavioral." Such skill-training strategies assume that the client is already in the "action" stage

TABLE 5.1. Contrasts between Confrontation of Denial and Motivational Interviewing

Confrontation-of-denial approach	Motivational interviewing approach
Heavy emphasis on acceptance of self as having a problem; acceptance of diagnosis seen as essential for change	De-emphasis on labels; acceptance of "alcoholism" or other labels seen as unnecessary for change to occur
Emphasis on personality pathology, which reduces personal choice, judgment, and control	Emphasis on personal choice and responsibility for deciding future behavior
Therapist presents perceived evidence of problems in an attempt to convince the client to accept the diagnosis	Therapist conducts objective evaluation, but focuses on eliciting the client's own concerns
Resistance is seen as "denial," a trait characteristic requiring confrontation	Resistance is seen as an interpersonal behavior pattern influenced by the therapist's behavior
Resistance is met with argumentation and correction	Resistance is met with reflection
Goals of treatment and strategies for change are prescribed for the client by the therapist; client is seen as "in denial" and incapable of making sound decisions	Treatment goals and change strategies are negotiated between client and therapist, based on data and acceptability; client's involvement in and acceptance of goals are seen as vital

TABLE 5.2. Contrasts between Skill Training and Motivational Interviewing

Skill-training approach <i>CPT</i>	Motivational interviewing approach
Assumes that the client is motivated; no direct strategies are used for building motivation	Employs specific principles and strategies for building client motivation for change
Seeks to identify and modify maladaptive cognitions	Explores and reflects client perceptions without labeling or "correcting" them
Prescribes specific coping strategies	Elicits possible change strategies from the client and significant others
Teaches coping behaviors through instruction, modeling, directed practice, and feedback	Responsibility for change methods is left with the client; no training, modeling, or practice
Specific problem-solving strategies are taught	Natural problem-solving processes are elicited from the client and significant others

and is motivated for change. The emphasis is on teaching the person *how* to change, rather than building commitment (the *why*) to change. Unlike motivational interviewing, these approaches are often highly prescriptive, offering specific directions, instructions, and assignments. Although motivational interviewing can be used as a preparation for skill training, the approaches are readily differentiated. The key points of contrast are shown in Table 5.2.

Nondirective Approaches

Motivational interviewing incorporates many of the insights and strategies described by Carl Rogers, but it differs in several ways from a classic "Rogerian" style, as well as from other nondirective (e.g., existential) approaches. Although motivational interviewing can be accurately described as client-centered, it is quite directive. The counselor typically has a clear goal (e.g., to change drinking and reduce alcohol-related problems) and pursues systematic strategies to achieve that goal. The counselor's own feedback and advice are given. Empathic reflection is used selectively, to reinforce certain points while de-emphasizing others. Furthermore, as we discuss shortly, the counselor is often working actively to create discomfort and discrepancy, rather than passively following the client's own offerings. These differences are summarized in Table 5.3.

TABLE 5.3. Contrasts between Nondirective and Motivational Interviewing Approaches

Nondirective approach	Motivational interviewing approach
Allows the client to determine the content and direction of counseling	Systematically directs the client toward motivation for change
Avoids injecting the counselor's own advice and feedback	Offers the counselor's own advice and feedback where appropriate
Empathic reflection is used noncontingently	Empathic reflection is used selectively, to reinforce certain processes
Explores the client's conflicts and emotions as they exist currently	Seeks to create and amplify the client's discrepancy in order to enhance motivation for change

Five General Principles

To help you see the forest before we get to the trees, we now outline five broad clinical principles underlying motivational interviewing. These incorporate but differ from the principles first outlined by Miller (1983). They are as follows:

1. Express empathy.
2. Develop discrepancy.
3. Avoid argumentation.
4. Roll with resistance.
5. Support self-efficacy.

We explain these five basic principles in this chapter, saving the "how-to" strategies for Chapters 6–10.

1. Express Empathy

An empathic therapist style is one essential and defining characteristic of motivational interviewing. As we have discussed in Part I, the therapeutic skill of "accurate empathy," as described by Carl Rogers, has been shown to be predictive of success in treating problem drinkers. This style of empathic warmth and reflective listening is employed from the very beginning and throughout the process of motivational interviewing.

The attitude underlying this principle of empathy might be called "acceptance." Through skillful reflective listening, the therapist seeks to

understand the client's feelings and perspectives without judging, criticizing, or blaming. It is important to note here that acceptance is not the same thing as agreement or approval. It is possible to accept and understand a client's perspective but not to agree with it. Nor does an attitude of acceptance prohibit the therapist from differing with the client's views. The crucial attitude is a respectful listening to the client with a desire to understand his or her perspectives. Paradoxically, this kind of acceptance of people *as they are* seems to free them to change, whereas insistent nonacceptance ("You're not OK; you have to change") can have the effect of keeping people as they are. This attitude of acceptance and respect also builds a working therapeutic alliance, and supports the client's self-esteem—an important condition for change (Miller, 1983).

An empathic therapist seeks to respond to a client's perspectives as understandable, comprehensible, and (within the client's framework, at least) valid. Ambivalence is accepted as a normal part of human experience and change, rather than seen as a pathological trait or pernicious defensiveness. Reluctance to give up a problem behavior is to be expected at the time of treatment; otherwise, the person would probably have changed before this point. The client is not seen as uniquely pathological or incapable. Rather, the client's situation is understood as one of being "stuck" through understandable psychological principles.

PRINCIPLE 1: EXPRESS EMPATHY.

Acceptance facilitates change.
Skillful reflective listening is fundamental.
Ambivalence is normal.

2. Develop Discrepancy

We certainly do *not* mean that the general goal of motivational interviewing should be to have clients accept themselves as they are and stay that way. Neither do we advocate using reflective listening simply to follow clients wherever they happen to wander. A person who presents with a health-threatening drug habit can be motivated to change that habit. This certainly does involve, in at least one sense of the term, "confronting" the client with an unpleasant reality. The question is how best to accomplish this.

A second general principle of motivational interviewing is thus to create and amplify, in the client's mind, a discrepancy between present behavior and broader goals. In the original exposition of motivational interviewing, Miller (1983) described this as creating "cognitive dissonance," borrowing a

concept introduced by Festinger (1957). A more general and, we believe, a better way to understand this process is simply as a discrepancy between where one is and where one wants to be. This can be triggered by an awareness of the *costs* of the present course of behavior. When a behavior is seen as conflicting with important personal goals (such as one's health, success, family happiness, or positive self-image), change is likely to occur. Consider this example given by Premack (1970) of a man who

dates his quitting [smoking] from a day on which he had gone to pick up his children at the city library. A thunderstorm greeted him as he arrived there; and at the same time a search of his pockets disclosed a familiar problem: he was out of cigarettes. Glancing back at the library, he caught a glimpse of his children stepping out in the rain, but he continued around the corner, certain that he could find a parking space, rush in, buy the cigarettes, and be back before the children got seriously wet. The view of himself as a father who would "actually leave the kids in the rain while he ran after cigarettes" was . . . humiliating, and he quit smoking. (p. 115)

No one "confronted" this man. No one else may have known what a significant event was occurring in his life. But in fact he was confronted by an unpleasant reality about himself, and it triggered a change. This kind of story—in which a life event changes one's perception of a habit—is common in the reports of people who have quit using alcohol, tobacco, or other drugs on their own. It is difficult, of course, for a therapist to arrange for such an event to occur. The *principle*, however, is one that is quite central to motivational interviewing. Motivation for change is created when people perceive a discrepancy between their present behavior and important personal goals (Miller, 1985b).

Many people who seek consultation already perceive some discrepancy between where they are and where they want to be. Yet they are also ambivalent, caught in an approach-avoidance conflict. A goal of motivational interviewing is to *develop* discrepancy—to make use of it, increase it, and amplify it until it overrides attachment to the present behavior. The strategies of motivational interviewing seek to do this *within* the client, rather than relying primarily upon external motivators (e.g., pressure from the spouse, threat of unemployment, or court-imposed contingencies). This involves clarifying important goals for the client, and exploring the consequences or potential consequences of his or her present behavior which conflict with those goals. When successfully done, motivational interviewing changes the client's perceptions (of discrepancy) without creating a feeling of being pressured or coerced.

The general approach is one that results in the *client's* presenting the reasons for change, rather than the counselor's doing so. People are often more persuaded by what they hear themselves say than by what other people

tell them. When motivational interviewing is done well, it is not the therapist but the client who gives voice to concerns (e.g., "This problem is more serious than I realized") and intentions to change (e.g., "I've got to do something about this").

PRINCIPLE 2: DEVELOP DISCREPANCY.

Awareness of consequences is important.

A discrepancy between present behavior and important goals will motivate change.

The client should present the arguments for change.

3. Avoid Argumentation

A third important principle of motivational interviewing is that the counselor avoids arguments and head-to-head confrontations. The least desirable situation, from this viewpoint, is one in which the counselor is arguing that the client has a problem and needs to change, while the client is defending an opposite viewpoint. This is a trap that we discuss in detail in Chapter 6.

Motivational interviewing is confrontational in its purpose: to increase awareness of problems and the need to do something about them. A casual observer of this counseling approach, however, would not be likely to label it as "confrontational." One experienced therapist in a workshop we were offering called it "soft confrontation." It is this gently persuasive style that is a hallmark of motivational interviewing.

Direct argumentation tends to evoke reactance from people; that is, it results in their asserting their freedom to do as they please. The more you tell someone "You can't," the more likely she or he is to respond "I will." Strongly defending a position (e.g., "You have a problem and you've got to change") is likely to elicit opposition and defensiveness from the client. As we have discussed in Part I, client resistance is strongly affected by how the therapist responds, and resistance during treatment is predictive of failure to change. For these reasons, it is a general goal in motivational interviewing to avoid approaches that evoke client resistance. When resistance is encountered, the therapist shifts strategies.

One place where arguments are quite likely to emerge, particularly in counseling addictive behaviors, is in regard to the applicability of a diagnostic label. Some counselors place great importance on a client's willingness to "admit" to a label such as "alcoholic." (In fact, in most other problem areas

there is usually little emphasis placed on a client's acceptance of a diagnostic label.) Trying to force a client to accept such a label can be countertherapeutic, however, and there is no evidence to suggest that recovery is promoted by persuading people to admit to a diagnostic label. Within Alcoholics Anonymous (AA), the emphasis has been more on self-recognition than on coerced admission. Bill Wilson wrote, "We do not like to pronounce any individual as alcoholic, but you can quickly diagnose yourself" (Alcoholics Anonymous, 1976, p. 31). No doubt some people do find it an important turning point when they first accept their problem. Our point here is that there is no particular reason why the therapist should badger clients to accept a label, or exert great persuasive effort in this direction. van Bilsen and van Emst (1986) observed, "Our experience was that we were often fighting against our clients instead of motivating them for change" (p. 707). Accusing clients of being "in denial" or "resistant" or "addicted" is more likely to increase their resistance than to instill motivation for change. We advocate starting with clients wherever they are, and altering their self-perceptions not by arguing about labels, but through substantially more effective means.

PRINCIPLE 3: AVOID ARGUMENTATION.

Arguments are counterproductive.

Defending breeds defensiveness.

Resistance is a signal to change strategies.

Labeling is unnecessary.

4. Roll with Resistance

If you don't argue, then what *do* you do? Jay Haley and other pioneers in the field of strategic family therapy have spoken of "psychological judo." They refer to the kinds of martial arts in which an attack is not met with direct opposition (as in boxing), but rather the attacker's own momentum is used to good advantage. It makes no difference what one throws at a master of this art. All blows fall on empty air, and the harder one attacks, the faster one falls into nothing.

This is not to say that the master is passive. Not at all. He or she *adds to* the momentum—a little spin, a glance to the side, an extra tug. The fall is inevitable, but the master is in control of *where* the other person lands. Often it is not where the person intended to land, and there may be the surprise of "How did I get over here?"

Any analogy can be taken too far. Motivational interviewing is not like

combat; it is not about winning and losing. The client is not an opponent to be defeated. Yet the illustration of rolling with resistance is useful. We explain in Chapter 8, for example, how statements that a client offers can be turned or reframed slightly to create a new momentum toward change. The object in motion is not a body but a perception. The client starts by throwing out present perceptions, and finds (if the counselor, the "master," is skillful) that they come down in a new place.

There is also an element of great respect for the client. What to do about a problem, if anything, is ultimately the client's decision. Reluctance and ambivalence are not opposed, but are acknowledged by the therapist to be natural and understandable. The counselor does not *impose* new views or goals. Rather, the client is invited to consider new information and is offered new perspectives. "Take what you want and leave the rest" is the permissive kind of advice that pervades this approach. It's an approach that is hard to fight against.

In motivational interviewing, the counselor also commonly turns a question or problem back to the client. It is not the therapist's job to generate all the solutions. Doing so, in fact, allows the client to dismiss each idea with "Yes, but . . ." It is assumed that the client is a capable individual, with important insight and ideas for the solution of his or her own problems. Rolling with resistance, then, includes involving the client actively in the process of problem solving.

PRINCIPLE 4: ROLL WITH RESISTANCE.

Momentum can be used to good advantage.

Perceptions can be shifted.

New perspectives are invited but not imposed.

The client is a valuable resource in finding solutions to problems.

5. Support Self-Efficacy

A fifth important principle of motivational interviewing involves the concept of "self-efficacy." As discussed in Chapter 3, self-efficacy refers to a person's belief in his or her ability to carry out and succeed with a specific task. Self-efficacy is a key element in motivation for change (Bandura, 1977, 1982; Rogers & Mewborn, 1976) and a good predictor of treatment outcome with addictive behaviors (Condiotte & Lichtenstein, 1981; DiClemente, 1981; DiClemente, Prochaska, & Gilbertini, 1985; Godding & Glasgow,

1985; Solomon & Annis, 1990; Wilkinson & LeBreton, 1986). A therapist may follow the first four principles outlined above, and persuade a person that he or she has a serious problem. If, however, the person perceives no hope for change, then no effort will be made, and the therapist's efforts have been in vain.

Although the term "self-efficacy" is relatively recent, healers have long recognized that hope and faith are important elements of change (Frank, 1973; Miller, 1985a; Shapiro, 1971). The therapist's own expectations about a client's chances for recovery can have a powerful impact on outcome (Leake & King, 1977; Parker, Winstead, & Willi, 1979). A general goal of motivational interviewing is to increase the client's perceptions of his or her capability to cope with obstacles and to succeed in change (Miller, 1983).

In presenting our first principle—"Express empathy"—we have discussed the importance of supporting self-esteem, the person's general self-regard. Although self-efficacy can be influenced by general self-esteem, the former is much more specific. Essentially, self-efficacy means confidence in one's ability to cope with a specific task or challenge. A client may, for example, suffer from very low self-esteem, but nevertheless may be persuaded that it is possible and within his or her ability to change a particular problem. Even approaches such as AA, which emphasize personal powerlessness over a problem, also stress that it is within the person's own power to change—in this case, by deciding to turn over control to a higher power, to take control by giving up control (Baugh, 1988). The overall message here is "You can *do* it. You can succeed."

There are various messages that support self-efficacy. One is an emphasis on personal responsibility (discussed, along with self-efficacy, in the "FRAMES" model of Chapter 3). The person not only *can* but *must* make the change, in the sense that no one else can do it for him or her. Motivational interviewing does not foster hope that the therapist will change the client. "I will change you" is not the intended message. A more appropriate message is "If you wish, I will help you to change yourself." A client may also be encouraged by the success of others. Contact with former clients as models can be helpful in this regard (Zweben & Li, 1981), but counselors also use accounts of the numbers of people who have succeeded in changing, or specific success stories. Still another helpful fact is the number of different approaches that are available and that have been shown to be helpful (e.g., Hester & Miller, 1989). Even a series of treatment failures need not be viewed as cause to abandon hope. It can be understood as this particular person's not yet having found the right approach. Given the range of different and promising treatment options, the chances of any given individual's finding something that works are quite good (Miller & Hester, 1986b). This is one emphasis within the "menu" element of the FRAMES model.

PRINCIPLE 5: SUPPORT SELF-EFFICACY.

Belief in the possibility of change is an important motivator.

The client is responsible for choosing and carrying out personal change.

There is hope in the range of alternative approaches available.

Summary

These five broad principles underlie the specific strategies that we describe in the next five chapters. We have discussed them apart from practical "how-to" elements, in order to give you a larger context regarding the "why" of practice. These principles bespeak a more general philosophy behind motivational interviewing. We believe that each person possesses a powerful potential for change. Your task as a therapist is to release that potential, to facilitate the natural change processes already inherent in the individual. In this approach, the client is treated with great respect, and as an ally rather than an opponent. Motivational interviewing is about helping to free people from the ambivalence that entraps them, yielding repetitive cycles of self-defeating or self-destructive behavior. It is more than a set of techniques for *doing* counseling. It is a way of *being* with clients, which is probably quite different from how others may have treated them in the past. This way of being is not the whole story of change. There are many specific treatment strategies that can be quite helpful as people pursue the course of change (e.g., Garfield & Bergin, 1986; Hester & Miller, 1989). Motivational interviewing is intended to get the person unstuck, to start the change process happening. Once begun, change may occur rapidly with relatively little additional assistance (see Chapter 3), or it may require a long span of therapeutic direction and support.

We turn now to six chapters on specific strategies of motivational interviewing. In the first of these, Chapter 6, we introduce strategies that are important from the outset, and that can help you avoid some common traps that await you. These strategies are most appropriate for *building motivation* to change, the first of two major phases of motivational interviewing. In Chapter 7 we explain ways in which pretreatment assessment results can be used as motivational feedback, and explore ways to assess readiness for change. Chapter 8 provides strategies for recognizing and coping with client resistance, particularly during the first phase of motivational interviewing. Then in Chapter 9, we proceed to discuss strategies appropriate for *strengthening commitment* to change, the second phase of motivational

interviewing. Chapter 10 explores a few typical but difficult situations that can arise in the application of motivational interviewing, and ways in which these special challenges can be met. Finally, in Chapter 11, we describe a practical case from start to finish, in order to illustrate how the strategies of motivational interviewing are interwoven.

6

Phase I: Building Motivation for Change

What you need, in trying to help people, are the qualities of a good bartender—sympathy, willingness to listen, and intuition.

—Frank Buchman, quoted in Garth Lean, *Frank Buchman: A Life*

Starting a counseling process is not unlike starting a game of chess. Everything is neat and ordered to begin with, yet within minutes both players can become immersed in complexity. One cannot know beforehand exactly what moves should be made, but a clear idea of the overall game plan is of great benefit. The number of specific situations that one can face is nearly infinite; yet one can know beforehand a set of general strategies that are quite helpful in coping with the complexities of play. Part of this knowledge involves understanding what *not* to do, particularly at the outset. It also includes recognition of common problems and traps that may be encountered, and how to prevent or at least recover from them. There are different approaches for opening, middle game, and endgame, although the strategies overlap.

The overall goal in this first phase of counseling is to *build motivation for change*. The assumption here is that the client is ambivalent, and in the contemplation or even precontemplation stage. This chapter contains some opening strategies for motivational interviewing that will allow you to put into practice the principles outlined in Chapter 5. We explain some traps that can be encountered early in motivational interviewing, and use specific examples of counseling dialogue to illustrate how counselors can succumb to or surmount these pitfalls. First, however, we want to say a few things about the opening session, and some common traps into which counselors can fall at the very beginning.

About the First Session

The very first session can be crucial, setting both the tone and the expectations for counseling. The therapist's actions even in a single session can have

a powerful influence on client resistance and long-term outcome (Miller & Sovereign, 1989). It is important, then, to adopt the proper approach right from the beginning, and to avoid falling into several traps that can quickly undermine progress.

The Question-Answer Trap

At the beginning of a counseling process, it is easy to fall into a pattern wherein the counselor asks questions and the client gives short answers. This is similar to what may occur when a physician conducts a general health screening: The patient responds "Yes" or "No" to a long survey of potential problem areas. This can happen in part because the counselor feels a need for specific information. It may also be a response to anxiety—either in the counselor, who wants to keep control, or in the client, who is more comfortable with the safe predictability of this passive role. In tone, the "expert" counselor controls the session by asking questions, while the client merely responds with appropriate short answers. Here is an example:

THERAPIST: You're here to talk about your gambling, is that right?

CLIENT: Yes, I am.

T: Do you think you gamble too much?

C: Probably.

T: What is your favorite game?

C: Blackjack.

T: Do you usually drink when you gamble?

C: Yes.

T: Have you ever gone seriously into debt because of gambling?

C: Once or twice, yes.

T: How far into debt?

C: Once I had to borrow \$8,000 to pay off a debt.

T: Are you married?

C: No, I'm divorced.

T: How long ago were you divorced?

C: Two years ago.

And so it can happen. There are several negative aspects of this trap. First, it teaches the client to give short, simple answers, rather than the kind of elaboration you will need for motivational interviewing. Second, it implies

an interaction between an active expert and a passive patient: If you just ask enough questions, then you will have the answer. It also affords little opportunity for the client to explore and to offer self-motivational statements, which we soon describe as a crucial process in motivational interviewing.

This trap is relatively easy to avoid. We recommend having clients complete a precounseling questionnaire to give you the specific information you may need at the outset, and saving the other specifics for later. This saves you going through an inventory of short-answer questions. The open-ended questions and reflective listening strategies explained later in this chapter are also very helpful in getting around the question-answer trap.

There is, however, a subtler form of this same trap, which involves open-ended questions. The optimal approach is usually to ask an open-ended question, then to respond to the client's response *not* with another question, but with reflective listening. The use of a series of open-ended questions without sufficient reflective listening can have a very similar effect to that of a series of closed questions. The client is directed into a passive, question-answering role. As a general rule, avoid asking three questions in a row.

The Confrontation-Denial Trap

For purposes of motivational interviewing, the confrontation-denial trap is the most important trap to avoid, and a common trap it is. Therapists fall into it through their own good intentions, and through a faulty understanding of motivational processes. If a therapist makes the wrong openings, most clients will readily play along with the pattern.

How does this trap happen? The familiar script is that the counselor detects some information indicating the presence of "a problem" (e.g., "alcoholism"), begins to tell the client that he or she has a serious problem, and prescribes a particular course of action. The client then expresses some reluctance about this, making statements along two general lines: (1) "My problem isn't really *that* bad," and (2) "I don't really need to change that much."

This is actually quite predictable. If, as we assume, people usually enter counseling in a state of ambivalence, they feel two ways about their situation: They want it, and they don't want it. They think maybe they should change, and yet they are reluctant to give up their present pattern. They are in conflict. If the counselor argues for one side of the conflict, it is very likely that the client will give voice to the other side. Here is a sample:

THERAPIST: Well, it seems to me that you have a serious drinking problem. You're showing a lot of the signs of alcoholism.

CLIENT: What do you mean?

T: Well, you've had an alcoholic blackout, you're uncomfortable when you can't drink, and you're losing control of your drinking.

C: But a lot of people I know drink just like I do.

T: Maybe so, maybe not. But we're not talking about other people, we're talking about you.

C: But I don't think it's that serious.

T: Not serious! It's just sheer luck that you haven't been arrested or killed somebody driving after drinking.

C: I told you, I can drive just fine. I've never had a problem.

T: And what about your family? They think you're drinking too much, and they think you ought to quit.

C: Oh, Fran came from a family of teetotalers. There's nothing wrong with me. They think anybody who has three drinks is an alcoholic.

From the viewpoint of motivational conflict, presented in Chapter 4, this pattern is quite predictable and understandable. By taking responsibility for the "problem-change" side of the conflict, the therapist elicits oppositional "no-problem" arguments from the client.

What happens next? The therapist may regard the client's reactions as proof of the "alcoholic trait of denial," which confirms the diagnosis. Within this view, the appropriate response is to turn up the heat—to confront the client's denial all the more aggressively (see Chapter 1). The result of this is also rather predictable: As the therapist argues one side more adamantly, the client will defend the other with greater vigor. It is a familiar script, and probably one that the client has been through before with others.

If the client begins to feel trapped, the phenomenon of psychological reactance (see Chapter 1) may also be evoked: The person asserts freedom to do as he or she pleases. The end result is an escalating head-to-head power struggle. The more the therapist confronts, the more the client becomes resistant and unwilling to change (Miller & Sovereign, 1989). Clients in this situation can literally talk themselves out of changing. Hearing themselves vigorously arguing that they don't have a problem and don't need to change, they become convinced. Few people enjoy losing an argument or being proved wrong.

This is the confrontation-denial trap. It can occur at any stage in counseling, but it is particularly common in the early phase, where it can set a very unhelpful tone. It can focus on any of a wide range of topics, not just whether or not the person has "a problem." In fact, this trap can emerge any time the counselor is arguing with a client. Two of the central strategies of motivational interviewing—reflective listening and eliciting self-motiva-

tional statements—are good approaches for preventing this problem. The strategies for dealing with resistance that we present in Chapter 8 are also helpful in avoiding this trap.

The Expert Trap

The enthusiastic and competent counselor can unwittingly fall into the expert trap by conveying the impression of having all the answers. Like the question-answer trap, its most common effect is to edge clients into a passive role, which is inconsistent with the basic approach of motivational interviewing—giving people the opportunity to explore and resolve ambivalence for themselves. A sincere desire to help can lead a counselor to try to “fix” the situation for a client, to prescribe answers and solutions. There is a time for expert opinion (see Chapter 9), but the focus in this approach is first on building the client’s own motivation. This is not likely to happen if the client is placed in the role of passive recipient of expert advice.

The Labeling Trap

Counselors and clients can also easily be ensnared by the issue of diagnostic labeling. Counselors sometimes believe that it is terribly important for a person to accept the counselor’s labeling (“You’re an alcoholic,” “You’re in denial,” etc.). Because such labels often carry a certain stigma in the public mind, it is not surprising that people with reasonable self-esteem resist them. As we have discussed earlier, there is little apparent value in pressuring people to accept such labels, and the Alcoholics Anonymous (AA) philosophy specifically recommends against such labeling of others.

Often there is an underlying process in a labeling debate. It may be a power struggle in which the counselor seeks to assert control and expertise, or a judgmental communication. For some clients, even a seemingly harmless reference to “your problem with . . . ” can elicit feelings of being cornered and uncomfortable. The danger, of course, is that the labeling struggle evokes resistance from the client, which in turn hinders progress. Since there are no important clinical advantages in imposing a label, the risk of descending into a confrontation-denial loop is simply not worth taking.

We recommend, therefore, that you *de-emphasize labeling* in the course of motivational interviewing. Problems can be fully explored without attaching labels that evoke unnecessary resistance. If the issue of labeling never comes up, it is not necessary to raise it. Often, however, a client will raise the issue, and how you respond can be quite important. We recom-

mend a combination of reflection and reframing—two techniques to be discussed later. Here is a brief example.

CLIENT: So are you implying that I'm an addict?

THERAPIST: No, I really don't care that much about labels. But it sounds like you do, that it's a worry for you.

C: Well, I don't like being called an addict.

T: When that happens, you feel like saying that your situation really isn't that bad.

C: Right! I'm not saying that I don't have any problems . . .

T: But you don't like being labeled as "having a problem." That sounds too harsh to you.

C: Yes, it does.

T: That's pretty common, as you might imagine. Lots of people I talk to don't like being labeled. There's nothing strange about that. I don't like people labeling me, either.

C: I feel like I'm being put in a box.

T: Right. So let me tell you how I see this, and then we'll move on. To me, it doesn't matter what we *call* a problem. I don't care if we call it "addiction" or "problems" or "Fred," for that matter. We don't have to call it anything. If you'd like a label, I could give you one, but that's not important to me. What really matters is to determine how your use of cocaine is harming you, and what, if anything, you want to do about it. That's what I care about.

As a final note, we would add that we also see no strong reason to *discourage* people from accepting a diagnosis if they are so inclined. Members of AA, for example, often report that it was important for them to recognize and accept their alcoholism. There is little point in opposing such self-acceptance. Our emphasis here is not to get into debates and struggles over labels.

The Premature-Focus Trap

Even if the counselor avoids arguments and labels, resistance may result if client and therapist wish to focus on different topics. In addictions counseling, for example, it is not uncommon for the therapist to want to hone in quickly on the client's alcohol and other drug use and related problems, while

the client wishes to discuss a broader range of concerns. A struggle may ensue regarding how much attention should be paid to what the counselor perceives to be "the problem." Indeed, in the client's mind, alcohol/drug use may be a relatively small part of the picture, and it may not be clear whether and how this is related to the client's larger concerns. If the counselor presses too quickly to focus the discussion on addiction, the client may be put off and become defensive. Other clients, however, present their drinking or drug use as a primary concern. In this case, early focusing is quite appropriate. The point is to avoid becoming engaged in a struggle about the proper topic for early discussion. Starting with the client's concerns, rather than those of the counselor, will ensure that this does not happen.

The Blaming Trap

Still another obstacle that can be encountered in the first session is a client's concern with blaming. Whose *fault* is the problem? Who's to blame? If this issue arises and is not dealt with properly, needless time and energy can be wasted on defensiveness. The obvious key here is that blame is irrelevant. Usually this can be dealt with by reflecting and reframing the client's concerns. If this problem arises, for example, the client may be told,

It sounds like you're worried about who's to blame here. I should explain that counseling is not about deciding who is at fault. That's for the courts. Counseling has a "no-fault" policy. I'm not interested in looking for who's responsible, but rather what's troubling you, and what you might be able to do about it.

Concerns about blame may also be prevented by offering a brief structuring statement at the beginning of counseling. If the client has a clear understanding of the purpose of counseling, worries about blaming may be averted.

Opening Structure

Clients come to counseling with widely varying expectations. They may come expecting to be criticized, healed, advised, questioned, listened to, blamed, taught, medicated, or consoled. Prospective clients enter treatment with widely differing expectations, fears, hopes, and concerns. For this and other reasons, it can be useful at the outset to provide the client with a simple and brief structuring of the first session, and of counseling in general. A good structuring statement can set the client's mind at rest and get

counseling off to a good start. Some elements that may be included in a good structuring statement are as follows:

- The amount of time you have available
- An explanation of your role and goals
- A description of the client's role
- A mention of details that must be attended to
- An open-ended question

Here is an example:

We have about an hour together now, and in this time I want to get a beginning understanding of what brings you here. I'll probably spend most of this time listening, so that I can understand how you see things and what your concerns are. You must also have some hopes about what will and won't happen here, and I'll want to hear about those. Toward the end of this hour I'll need to ask you for some specific information that I need, but let's just get started now. What's on your mind? I understand that you have some concerns about your use of tranquilizers. . . .

Five Early Strategies

The first four strategies described below are derived largely from client-centered counseling, although in motivational interviewing they are used for a particular purpose—that of helping clients to explore their ambivalence and express reasons for change. The fifth strategy is more directive and is specific to motivational interviewing. It integrates and guides the use of the other four strategies.

1. Ask Open-Ended Questions

During the early phase of motivational interviewing, it is important for the therapist to establish an atmosphere of acceptance and trust, in which the client will explore his or her problems. This means that the *client* should do most of the talking at this stage, with the counselor listening carefully and encouraging expression. The first four of these five early strategies directly support this goal.

One way to begin this process is to ask early questions in a way that encourages the client to do most of the talking. Short-answer questions are

necessary in most sessions, but should not be emphasized during the early phase of motivational interviewing. It is better to begin with *open-ended* questions—ones that cannot easily be answered with a brief reply. Such questions open the door for the client to explore. Some clients come in almost bursting to talk, and it takes only a simple invitation to elicit their story. Others are more guarded and require encouragement. How you respond to the client's initial answers will strongly influence what happens next, but that is taken up below. Our interest here is in how to ask good open-ended questions.

If you know in advance or otherwise sense that the client has clear concerns to talk about, a simple opening of the door may suffice. Here are some examples:

- I assume, from the fact that you are here, that you have some things you want to talk over with a counselor. What would you like to discuss?
- I'd like to understand how you see things. What's brought you here? What's been the problem?
- I understand that you have some concerns about drinking. Tell me about them.
- You said on the telephone that you have been using drugs for a long time, and you wanted to talk about it. Fill me in. Why don't you start from the beginning, when you first used drugs, and bring me up to date?

In discussing a focal problem with more ambivalent clients (e.g., ones in the early contemplation stage), it can be useful to ask for both sides of the coin, or to ask a connected cluster of more neutral-sounding questions. Some therapists prefer to ask clients first what they have liked about their current ("problem") behavior, and then what the negative side includes. Here are some possible openings:

- Tell me about your use of cocaine. What do you like about it? And what's the other side? What are your worries about using it?
- Tell me what you've noticed about your drinking over the years. Have you seen any changes in your drinking and how it affects you? What have you noticed that might concern you, or that has concerned other people?
- I understand that you're here to talk about your gambling. So help me see the whole picture here. What do you enjoy about gambling, and what's the darker side?

Obviously, people will vary in how they react to opening questions such as these. Some will respond eagerly to the opportunity to talk about their difficulties. In such cases, your job is a matter of guiding the person in this

exploration, using the strategies described in this and subsequent chapters. Others will volunteer relatively little, and may change the subject or head off into one of the traps described earlier. These questions are only door-openers, which provide opportunities for using other strategies.

2. Listen Reflectively

Perhaps the most challenging skill in motivational interviewing is that of reflective listening. In popular conceptions, listening just involves keeping quiet and hearing what someone has to say. The crucial element in *reflective* listening, however, is how the counselor *responds* to what the client says. Thomas Gordon (1970) has outlined 12 kinds of responses that are *not* listening:

1. Ordering, directing, or commanding
2. Warning or threatening
3. Giving advice, making suggestions, or providing solutions
4. Persuading with logic, arguing, or lecturing
5. Moralizing, preaching, or telling clients what they "should" do
6. Disagreeing, judging, criticizing, or blaming
7. Agreeing, approving, or praising
8. Shaming, ridiculing, or labeling
9. Interpreting or analyzing
10. Reassuring, sympathizing, or consoling
11. Questioning or probing
12. Withdrawing, distracting, humoring, or changing the subject

These responses have also been called "roadblocks" because they get in a client's way. In order to keep exploring in the same direction, the client has to deal with the roadblock and go around it. Roadblocks have the effect of blocking, stopping, diverting, or changing direction. They all imply an uneven or "one-up" relationship. A counselor who responds with one of these is not listening—at least not in the sense of reflective listening. Rather, the counselor is keeping quiet just long enough to think of a response from the list above, and then offering it. The underlying message is "Listen to me; I know best." Instead of continuing to explore the path, the client then has to deal with the roadblock. Consider this unhelpful "therapist" talking to a client who feels two ways about an important decision. (The number of each corresponding roadblock from the list above is given in parentheses.)

CLIENT: I just don't know whether to leave him or not.

THERAPIST: You should do whatever you think is best. (#5)

- C: But that's the point! I don't know what's best!
- T: Yes, you do, in your heart. (#6)
- C: Well, I just feel trapped, stifled in our relationship.
- T: Then you should separate for a while and see how you feel. (# 3)
- C: But I love him, and it would hurt him so much if I left!
- T: But if you don't do it, you could be wasting your life. (#2)
- C: But isn't that kind of selfish?
- T: It's just what you have to do to take care of yourself. (#4)
- C: I just don't know how I could do it.
- T: I'm sure you'll be fine. (#10)

This client has not been helped to explore ambivalence, but instead is prematurely pressed toward one resolution. The "counselor" in this situation has never really listened, has never given the client a chance to keep on talking and exploring. The client's time has been spent dodging roadblocks.

But what else is there? If one avoids all 12 roadblocks, what is there left to say? We don't mean to imply that it is *wrong* to use these 12 responses. There is a time and a place for each of them. We *do* mean to say that reflective listening is something different from these ways of responding. It has been extensively described by Rogers (1957), Truax and Carkhuff (1967), Gordon (1970), Ivey (1980), and Egan (1982), among others.

The essence of a reflective-listening response is that it makes a guess as to what the person *means*. Before a person speaks, he or she has a certain meaning to communicate. This is coded into words, often imperfectly. The listener has to hear the words accurately and then decode their meaning. That means there are three steps along the way where communication can go wrong: coding, hearing, and decoding (Gordon, 1970; Miller & Jackson, 1985). The reflective listener forms a reasonable guess as to what the original meaning was, and gives voice to this guess in the form of a *statement*.

A statement? Why not a question? After all, the listener is not sure whether the guess is correct. The reason is very practical: A well-formed reflective statement is less likely to evoke resistance. *Asking* about meaning, through questioning, seems to distance clients from experiencing it. They step back and begin to ask if they really do or should feel what they have expressed. The difference is subtle, and not everyone notices it. Consider the difference in sound between these reflections:

You're feeling uncomfortable?
You're feeling uncomfortable.

You're angry with your mother?
You're angry with your mother.

The difference is an inflection. The voice tone goes up at the end of a question, gently down at the end of a statement. Reflective-listening statements should usually turn *down* at the end.

In order to offer reflective listening, you first must train yourself to *think* reflectively. This includes the realization that what you *believe* or *assume* people mean is not necessarily what they really mean. Most statements can have multiple meanings. Emotion words such as "depressed" or "anxious" have very different meanings to different people. What could it mean for a person to say, "I wish I were more sociable"? Here are some possibilities:

I feel lonely and I want to have more friends.
I get very nervous when I have to talk to strangers.
I should spend more time getting to know people.
I would like to be popular.
I can't think of anything to say when I'm with people.
People don't invite me to their parties.

To think reflectively is to make this process more conscious. In fact, when you hear a statement, you consider what it might mean, and you choose what you believe to be the most likely meaning. Many people then act as if this *were* the actual meaning of the statement. Reflective listening is a way of checking, rather than assuming that you *know* what is meant.

Reflective listening, then, involves making a statement that is not a roadblock, but rather a *guess* about what the person means. Usually, but not always, the subject of the sentence is the pronoun "you." Here is an extended example from a counseling session with an ambivalent problem drinker. For illustrative purposes, every therapist sentence in this segment is a reflective-listening statement.

CLIENT: I worry sometimes that I may be drinking too much for my own good.

THERAPIST: You've been drinking quite a bit.

C: I don't really *feel* like it's that much. I can drink a lot and not feel it.

T: More than most people.

C: Yes. I can drink most people under the table.

T: 'And that's what worries you.

C: Well, that and how I feel. The next morning I'm usually in bad shape. I feel jittery and I can't think straight through most of the morning.

- T: And that doesn't seem right to you.
- C: No, I guess not. I haven't thought about it that much, but I don't think it's good to be hung over all the time. And sometimes I have trouble remembering things.
- T: Things that happen while you're drinking.
- C: That, too. Sometimes I just have a blank for a few hours.
- T: But that isn't what you meant when you said you have trouble remembering things.
- C: No. Even when I'm not drinking, it seems like I'm forgetting things more often, and I'm not thinking clearly.
- T: And you wonder if it has something to do with your drinking.
- C: I don't know what else it would be.
- T: You haven't always been like that.
- C: No! It's only the last few years. Maybe I'm just getting older.
- T: It might just be what happens to everybody when they reach 45.
- C: No, it's probably my drinking. I don't sleep very well, either.
- T: So maybe you're damaging your health and your sleep and your brain by drinking as much as you do.
- C: Mind you, I'm not a drunk. Never was.
- T: You're not that bad off. Still, you're worried.
- C: I don't know about "worried," but I guess I'm thinking about it more.
- T: And wondering if you should do something, so that's why you came here.
- C: I guess so.
- T: You're not sure.
- C: I'm not sure what I want to do about it.
- T: So if I understand you so far, you think that you've been drinking too much and you've been damaging your health, but you're not sure you want to change that.
- C: Doesn't make much sense, does it?
- T: I can see how you might feel confused at this point.

Notice that the therapist does not insert roadblocks throughout this process. It would have been easy to substitute some of the roadblocks for these reflections. This is avoided, however, because the purpose is to elicit self-motivational statements from the client.

Reflective-listening statements can be quite simple. Sometimes the mere repetition of a word or two will keep the client moving (in the example above, the first reflection could have been "Too much . . ."). A more sophisticated reflection substitutes new words for what the client has offered, or makes a guess about the unspoken meaning. Sometimes it is helpful, too, to reflect how the client seems to be *feeling* as he or she speaks.

Reflection is not a passive process. The counselor decides what to reflect and what to ignore, what to emphasize and de-emphasize, what words to use in capturing meaning. Reflection can be used to reinforce certain aspects of what a person has said, or to alter its meaning slightly. These applications of reflection are discussed in Chapter 8. We advise that reflective-listening statements should constitute a substantial proportion of counselor responses during the early phase of motivational interviewing. In particular, self-motivational statements should be reflected back. In this way, clients hear their own statements twice.

Reflection is particularly important following open-ended questions. Once you have asked an open question, respond to the client's answers with reflective listening. Because questioning is a much less demanding skill (for the counselor) than empathic listening, it is easy to fall into the question-answer trap, asking a series of questions instead of reflecting the client's statements. This may evoke resistance more than self-motivational statements. Remember, then, to follow up a question with reflective listening.

3. Affirm

It can also be quite helpful to affirm and support your client during the counseling process. This can be done in the form of compliments and statements of appreciation and understanding. The process of reflective listening can be quite affirming in itself, but direct affirmations have a place in counseling, too. Here are some examples:

I appreciate how hard it must have been for you to decide to come here.

You took a big step!

I think it's great that you want to do something about this problem.

That must have been very difficult for you.

You're certainly a resourceful person, to have been able to live with the problem this long and not fall apart.

That's a good suggestion.

It must be difficult for you to accept a day-to-day life so full of stress. I must say, if I were in your position, I would also find that difficult.

I guess that's why you're here—because you don't want to accept that kind of stress any more.
It seems like you're a really spirited and strong-willed person in a way. You enjoy being happy with other people, and making them laugh. In that way, it's hard to think about giving up drinking.
You're certainly having to cope with a lot of problems right now—more than most people. I can understand how sometimes you want a "lift" so badly, you want a release from it all.

4. Summarize

A fourth strategy to use early and throughout motivational counseling is summarizing. Summary statements can be used to link together material that has been discussed. When you are eliciting a client's self-motivational statements, for example, it is wise to summarize periodically:

So thus far you've said that you are worried with the *amount* that you are drinking, relative to other people, and how much you're spending on it. You're not sure what it means that you can drink so much more than other people without seeming to be affected. You're concerned that your drinking is damaging your memory, and that it keeps you from normal sleeping. What else?

Such periodic summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on. They also allow a client to hear his or her own self-motivational statements a third time!

Linking summaries can be especially helpful in expressing a client's ambivalence. The typical experience of ambivalence is to vacillate back and forth between reasons to change and reasons to stay the same. A summary statement is one way to allow a person to examine the positives and negatives *simultaneously*, acknowledging that both are present. Linking phrases, such as "on the one hand . . . on the other" and "at the same time," can be useful:

It sounds like you're torn two ways. On the one hand, you're very worried that drinking is hurting your family, and that your work is being affected as well. You're especially surprised that two different friends in the same week told you they are concerned about your drinking. At the same time, you certainly don't think of yourself as an alcoholic, and you find that you can go for a week at a time without drinking, without any bad effects. This must be puzzling for you.

Other sources of information can be incorporated into a summary as well. Results of objective assessment (see Chapter 7) and information from

the courts or family members can be combined with the client's own statements.

At the end of the first session, and at other points during motivational counseling, it is useful to offer a major summary, pulling together what has transpired thus far. Again, it should be noted that in giving such summaries, you must decide what to include and to emphasize. When you are introducing such a major summary, it is helpful to use a prefacing statement that announces what is to follow. Here is an example of a fairly complete summary at the end of a first session:

Our hour is running out, and I'd like to try to pull together what you've said so far, so we can see where we are and where we're going. Let me know if I miss anything important that we've covered. You came in because your husband is concerned about your drinking and your marijuana smoking. If he hadn't pushed you, you might not have come right now, but you've been very open in exploring this, and I admire you for that. I asked you about problems in your life that you think could be related to alcohol and marijuana, and you mentioned several. You've been feeling quite depressed and tired, and as we discussed, alcohol is a depressant. You said you are having a lot of trouble concentrating, and that you're feeling as if you aren't motivated to do anything in your life. Again, rightly, you think this might be linked to your drinking and smoking, although you think that's not the whole picture. You resent your husband's sending you here, in a way, because you think he has a part in these problems too. The tests that you completed indicate that you have developed a fairly significant dependence on alcohol and, to a lesser extent, on marijuana, and that's a problem that can keep growing if you don't do something about it. When you were arrested that one time 2 years ago, your breath test showed that you were over .20, which is really quite intoxicated, even though you weren't feeling drunk. We talked about how this kind of tolerance is in itself a risk factor. You're also worried that you're not the kind of mother you want to be, in part because of drinking and smoking, and you don't want your kids to grow up with drug problems. Your doctor told you that your stomach problems are probably caused, or at least made worse by, your drinking. At the same time, you have liked alcohol and marijuana because you use them to relax and to get away from some heavy family stresses. You're not sure how you could handle life without drinking and smoking, and so you're not sure what to do. Is that a fair summary so far? What have I left out?

This kind of summary is a good way to draw the first session to a close. Notice the collaborative tone, allowing the client to add to or correct your summary. A somewhat shorter form of the same statement can be used to begin the next session, building upon progress made earlier. A major

summary of this kind is also used at the transition point from the first to the second phase of motivational interviewing (see Chapter 9).

5. Elicit Self-Motivational Statements

The preceding four strategies are fundamental to motivational interviewing. If these were the only strategies employed, however, it would be quite easy to become stuck in ambivalence. It is necessary, therefore, to have a guiding strategy to help clients resolve their ambivalence. That is the underlying purpose of the fifth strategy. The other four strategies can all be applied in this goal-directed approach.

In one sense, motivational interviewing is the opposite of a confrontation-of-denial approach, in which the therapist promotes the "problem-change" position and the client defends against it. We believe that such a confrontational approach is often detrimental, precisely because it causes the client to defend a "no-problem" position. Our goal is to have the client give voice to exactly the opposite kinds of statements. *In motivational interviewing, it is the client who presents the arguments for change.* It is the counselor's task to facilitate the client's expression of these self-motivational statements (Miller, 1983).

Self-motivational statements fall into four general categories. The first of these is *problem recognition*. (It is often a desire for problem recognition that leads counselors into labeling struggles, but the imposition of labels is usually an ineffective strategy.) Some examples of desirable problem recognition statements from clients are as follows:

I guess there's more of a problem here than I thought.
I never really realized how much I am drinking.
This is serious!
Maybe I *have* been taking foolish risks.
I can see that in the long run, my gambling is going to do me in.

A second and related kind of self-motivational statement is *expression of concern* about perceived problems. This is often communicated nonverbally, through the client's facial expressions, sighs, tears, or gestures. Some verbalizations of this kind are these:

I'm really worried about this.
How could this happen to me? I can't believe it!
I feel pretty hopeless.

The third type of self-motivational statement is direct or implicit *intention to change*. This can be expressed in the person's taking action as

an initial step to change (e.g., taking disulfiram) or in stated intentions to do so. A few examples of the latter are as follows:

I think it's time for me to think about quitting.
I've got to do something about this.
This isn't how I want to be. What can I do?
I don't know how I'm going to do it, but I've got to make a change.
How do people quit a habit like this?

Finally, self-motivational statements can express a theme of *optimism* about change. Such statements reflect an ability to make a difference (self-efficacy) in the problem area. Here are a few statements of this kind:

I think I can do it.
Now that I've decided, I'm sure I can change.
I'm going to overcome this problem.

These four kinds of statements reflect cognitive (recognition, optimism), affective or emotional (concern), and behavioral (intention to act) dimensions of commitment to change. From our perspective, every statement of this kind tips the balance a little further in the direction of change.

Some people walk through the counselor's door already saying things like this, and only need some help in confirming their commitment and planning a course of action. But how can a counselor evoke such statements from more ambivalent clients? This is one of the key skills of motivational interviewing.

Evocative Questions

A very direct approach is simply to ask the client for such statements. Open-ended questions can be used to explore the client's own perceptions and concerns. Don't ask *whether* the person has such concerns (e.g., "Do you think that you have a problem with drugs?"). Assume that the person is feeling ambivalent and that he or she *does* have such concerns. Open-ended questions for evoking each of the four categories of self-motivational statements are suggested in Table 6.1.

When the client offers a self-motivational statement, even tentatively, reinforce it nonverbally (e.g., with head nods) as well as verbally with reflective listening or a supportive statement (e.g., "I can see how that would concern you" or "That must be difficult for you"). Whether a client will continue offering self-motivational statements and exploring ambivalence and discrepancy depends largely on how you respond. It is important, therefore, to respond in a manner that communicates acceptance, reinforces

TABLE 6.1. Sample Questions to Evoke Self-Motivational Statements

1. Problem Recognition

What things make you think that this is a problem?
 What difficulties have you had in relation to your drug use?
 In what ways do you think you or other people have been harmed by your drinking?
 In what ways has this been a problem for you?
 How has your use of tranquilizers stopped you from doing what you want to do?

2. Concern

What is there about your drinking that you or other people might see as reasons for concern?
 What worries you about your drug use? What can you imagine happening to you?
 How do you feel about your gambling?
 How much does that concern you?
 In what ways does this concern you?
 What do you think will happen if you don't make a change?

3. Intention to Change

The fact that you're here indicates that at least a part of you thinks it's time to do something.
 What are the reasons you see for making a change?
 What makes you think that you may need to make a change?
 If you were 100% successful and things worked out exactly as you would like, what would be different?
 What things make you think that you should keep on drinking the way you have been? . . .
 And what about the other side? What makes you think it's time for a change?
 What are you thinking about your gambling at this point?
 What would be the advantages of making a change?
 I can see that you're feeling stuck at the moment. What's going to have to change?

4. Optimism

What makes you think that if you did decide to make a change, you could do it?
 What encourages you that you can change if you want to?
 What do you think would work for you, if you decided to change?

self-expression, and encourages continued exploration. Your responses should be encouraging, and should not imply that you are accumulating evidence to use against the client. The goal is to reinforce the client's self-motivational statements and to encourage him or her to continue.

Once the process has begun, straightforward encouragement to continue is often effective. The general form here is "What else?"

What else have you noticed or wondered about?
 What other concerns have you had?
 What are some other reasons why you may need to make a change?
 What other things have people told you?
 Why else do you think you could succeed?

What other problems have you had?
What else worries you about your drinking?

Remember that the overall purpose here is for the client to take responsibility for the "problem-change" side of the conflict. Periodic summaries of the client's self-motivational statements can be useful in moving the process along.

The Decisional Balance

As mentioned earlier, it can be helpful to have clients discuss the positive as well as the negative aspects of their present behavior. They may be asked, for example, to say or list what they *like* about their drinking or drug use, as a preface to inquiring about the negative side. This has the advantage of getting clients talking and feeling comfortable, as well as of clarifying both sides of the ambivalence. It can be useful to fill out a decisional balance sheet, like the one shown in Chapter 4 (see Table 4.1), to allow a client to see the full picture. Additional strategies can then be used to strengthen motivations for change. Often, however, simply talking about the negative side of the conflict leads directly to expressions of concern about it.

Elaboration

Once a motivational topic has been raised, it is useful to ask the client to elaborate. This helps to reinforce the theme and to elicit further self-motivational statements. One good way of doing this is to ask for specific examples, and for clarification as to why (how much, in what way) each one is a concern. Here is a demonstration:

CLIENT: One place where I see a problem is money.

THERAPIST: In what way is that a concern for you?

C: Well, I've been spending a lot of money on drugs and not paying my bills.

T: Give me an example.

C: Just last week I went through about \$400. I get started and I just keep going.

T: And it really adds up. How else does it affect your money?

C: I do stupid things when I'm high.

T: For example . . .

C: I lent \$300 to this guy I met. I'll never see that again. And I buy things I don't need.

T: Such as . . .

- C: A watch. One time I bought myself this really good watch. At least I *thought* it was a good watch. I spent a lot on it.
- T: How much does this money issue concern you?
- C: It's getting to be a big problem. I've got people coming to the door, calling on the telephone, sending nasty letters. I've got to do something.
- T: And it sounds like you think your use of drugs is part of your money troubles.
- C: A big part. Yes.

In the early stages of motivational interviewing, a useful target for elaboration is a typical day or session of use. Asking in detail about behavior and mood changes, for example, can highlight the positive reasons for using alcohol or other drugs; areas of concern also emerge quite naturally from such discussion.

Using Extremes

Clients can also be asked to describe the extremes of their concerns, to imagine worst consequences. Some questions of this type are as follows:

- What concerns you the *most*?
- What are your worst fears about what might happen if you don't make a change?
- What do you suppose are the worst things that might happen if you keep on the way you've been going?

Looking Back

Sometimes it is useful to have the person remember times before the problem emerged, and to compare these with the present situation. Here are some examples:

- Do you remember a time when things were going well for you? What has changed?
- What were things like before you started drinking so heavily? What were *you* like back then?
- Tell me about how you two met each other, and what attracted you to each other back then. What was it like?
- What are the differences between the Pat of 10 years ago and the Pat of today?
- How has your use of drugs stopped you from growing, from moving forward?

Looking back at past substance use often brings out the observation that the person's tolerance has markedly increased. This can be used as a powerful motivator if the counselor reframes this phenomenon as a danger sign, along the lines described in Chapter 8.

Looking Forward

Helping people to envision a changed future is another approach for eliciting self-motivational statements. Here you ask for the client to tell you how it might be after a change:

- If you do decide to make a change, what are your hopes for the future?
- How would you like things to turn out for you?
- I can see that you're feeling really frustrated right now. How would you like things to be different?
- What are the options for you now? What could you do?
- What would be the best results you could imagine if you make a change?

Exploring Goals

Yet another approach is to ask the client to tell you what things are most important in his or her life. (This can overlap nicely with the "looking forward" process.) What values or goals does this person hold most dear? Rokeach (1973) has described a simple procedure for assessing personal value hierarchies, whereby a set of cards describing possible values are arranged in rank order, according to which value the person prizes most highly. From the perspective of motivational interviewing, the purpose of this exploration is to discover ways in which the problem behavior is inconsistent with or undermines important values and goals for the client. When the highest or most central values and goals have been defined, you can ask how the problem you are discussing (e.g., drinking) fits into this picture. For a drinker, it would be possible to insert a card labeled "drinking" in the set to be sorted by Rokeach's method—a strategy that in itself can provoke useful discussion with a client. The central point here is to explore and develop themes of discrepancy between these important goals and the present problem behavior.

Paradox

Sometimes a skillful therapist can make use of paradox to encourage self-motivational statements. The term "paradox" can refer to a number of

different therapeutic tactics, but in this context we mean that the counselor subtly takes on the role of the "no-problem" side of the client's conflict. By stating this side of the conflict, the therapist intends to evoke the opposite—namely, statements of problem recognition, expression of concern, intention to change, and optimism. Here are a few examples of how a counselor might take on this role:

You've come all the way down here to talk to me about this, but you haven't convinced me yet that you've got a real concern. Is that *all*? Let me tell you something that concerns me. A program like this one requires a lot of motivation and effort. We don't really want to start working with somebody until they're sure they need to change, and frankly, I'm not sure about you. As I listen to you, I'm not convinced you're motivated enough.

I'm not sure you believe you could change even if you wanted to.

There is a clear test of whether such a strategy is working: If it evokes self-motivational statements from the client, it is working. But beware—paradoxes can backfire.

Sometimes a paradoxical evoking strategy can be used very directly, with the client's full awareness and participation. With certain clients, this can be quite beneficial and engaging:

One thing that I find is helpful is to clarify the real reasons for change. I've heard from you some of the reasons why you are reluctant to think about making a change, and now I have a suggestion. I want to have a little debate with you. I will defend the position that you don't really have a problem and don't need to change, and I'd like you to do your best to convince me otherwise. Do you understand? I'm going to be you, and your job is to persuade me that there really is a problem here that I need to examine and do something about. OK?

Clients sometimes need extra encouragement to get rolling with a role play of this kind. Have the client speak in "you" language, while you as the counselor speak in "I" language and voice the client's prior "no-problem" arguments. Here's how it might go:

THERAPIST: I just can't see what you think is the problem here. I drink just the same as my friends.

CLIENT: Well, you certainly drink more than a lot of your friends, and then some of your friends are pretty heavy drinkers themselves.

T: But that doesn't mean we've got a problem. I mean, what's the harm in having a drink?

C: It's not having a drink that's harmful. But you're the last to leave the party. (*Out of role:*) Am I doing OK?

T: (*Out of role:*) You're doing great. But don't go easy on me. Don't let me get away with anything. OK?

C: OK

T: (*In role:*) Well, I can handle it! I can drink all night and still not be drunk.

C: But what about the next morning . . . ?

Over time, the therapist allows the client to "persuade" him or her that there is reason for concern. This technique is not appropriate for every client, but it can be an appealing, even entertaining way to externalize and examine the ambivalence. At the same time, it is evoking many self-motivational statements from the client, who must defend the presence of harm and the need for change.

The eliciting of self-motivational statements is a very important strategy for developing discrepancy. Hearing oneself make statements such as these tends to increase awareness of the discrepancy between one's goals and present actions. The greater this discrepancy, the greater the motivation for change. The first four strategies for early motivational interviewing can be integrated into the development of discrepancy by (1) asking open-ended questions that pull for self-motivational statements; (2) reflecting back, sometimes selectively, the self-motivational aspects of what a client has said, which allows the client to hear it a second time; (3) affirming and reinforcing the client for making self-motivational statements; and (4) offering periodic summaries of self-motivational themes that the client has offered, allowing the client to hear them once again as statements that he or she has made. Other strategies, such as objective feedback (see Chapter 7), can also serve to increase perceived discrepancy (Miller, 1983). Phase I of motivational interviewing focuses primarily on building motivation through the amplification and clarification of discrepancy.

Realize that the eliciting of self-motivational statements can be important not only in early sessions, but throughout counseling. Ambivalence does not usually disappear, but only diminishes. The evoking of self-motivational statements can serve as a continuing reminder of the reasons for commitment to change.

Follow-Through Contact

The risk of a client's dropping out of treatment is highest following the first session. In some studies, the dropout rate in alcoholism treatment has been

well over 50%. The strategies outlined above may be helpful in reducing dropout, but one additional step has been shown to increase significantly the rate of clients' returning for further treatment. This is a simple follow-through contact.

In one study (Koumans, Muller, & Miller, 1967), alcoholics who made an initial contact with a psychiatric clinic were divided into two groups. The first 50 received only the ordinary referral procedures, whereas the next 50 received a single telephone call after their consultation. Of these two groups, 8% versus 52% returned for treatment, most of them within 1 week. That is, a single further contact increased the return rate by more than six times. In another study (Koumans & Muller, 1965), 50 alcoholics randomly selected after initial consultation to receive "a personal letter expressing concern for the patient's well-being and repeating our invitation to return for further assistance" were compared with 50 others receiving no letter. The return rates for outpatient treatment were 50% and 31%, respectively.

Simple follow-through contact can also be effective in preventing treatment dropout. One clinic (Nirenberg, Sobell, & Sobell, 1980) found that when clients failed to keep an appointment, a personal telephone call (but not standard letters) reduced the dropout rate from 92% to 60%. When the follow-through letter was changed from an impersonal format to one more clearly expressing an interest in the client, a letter alone reduced dropout from 96% to 66%. Panepinto and Higgins (1969) likewise found that a follow-through letter after the first missed appointment reduced early dropout from 51% to 28%. Intagliata (1976) found that telephone contacts nearly doubled the rate of aftercare attendance in alcoholics discharged from inpatient treatment. In short, simple expressions of caring and interest can have a major effect on a client's "motivation" to return for treatment (cf. Wedel, 1965).

We have thus far discussed ways to enhance client motivation during early contacts and sessions. In Chapter 7 we consider how information from a more careful assessment can be incorporated into the process of motivational interviewing.

7

Using Assessment Results

O wad some Pow'r the gifie gie us
To see oursel[ve]s as others see us!
It wad frae monie a blunder free us . . .

—Robert Burns, "To a Louse"

Most treatment programs include some form of pretreatment evaluation. The purposes of such assessment are several, and include (1) screening for problems; (2) establishing a diagnosis; (3) establishing eligibility and appropriateness for treatment; (4) understanding the individual more comprehensively; and (5) determining which form of treatment, if any, is most appropriate (Jacobson, 1989a). To the extent that treatment is individualized, a careful evaluation can help to determine optimal goals and strategies (Glaser et al., 1984; Gottheil, McLellan, & Druley, 1981; Miller, 1989b; Miller & Hester, 1986b).

There is, however, another important potential use of pretreatment assessment that is too often overlooked. This is to use evaluation results as part of motivational counseling. Providing the client with a thorough summary of findings can be very helpful in building motivation and strengthening commitment for change. In this chapter, we discuss several issues of individual evaluation, including (1) how to prepare clients for assessment, (2) what dimensions to include in a comprehensive pretreatment evaluation, (3) how to assess motivation itself, and (4) how to present your findings in a motivational manner.

Presenting Assessment

In the dimmest view, pretreatment assessment is seen by both counselor and client as an annoying set of hurdles and obstacles that must be crossed before treatment can commence. Such a view assumes that the evaluation is of no use in planning treatment—a sad commentary on the extent to which we may fail to individualize treatment according to the person's particular

MOTIVATIONAL INTERVIEWING

Building Motivation to Change

Principles of Motivational Interviewing

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self Efficacy

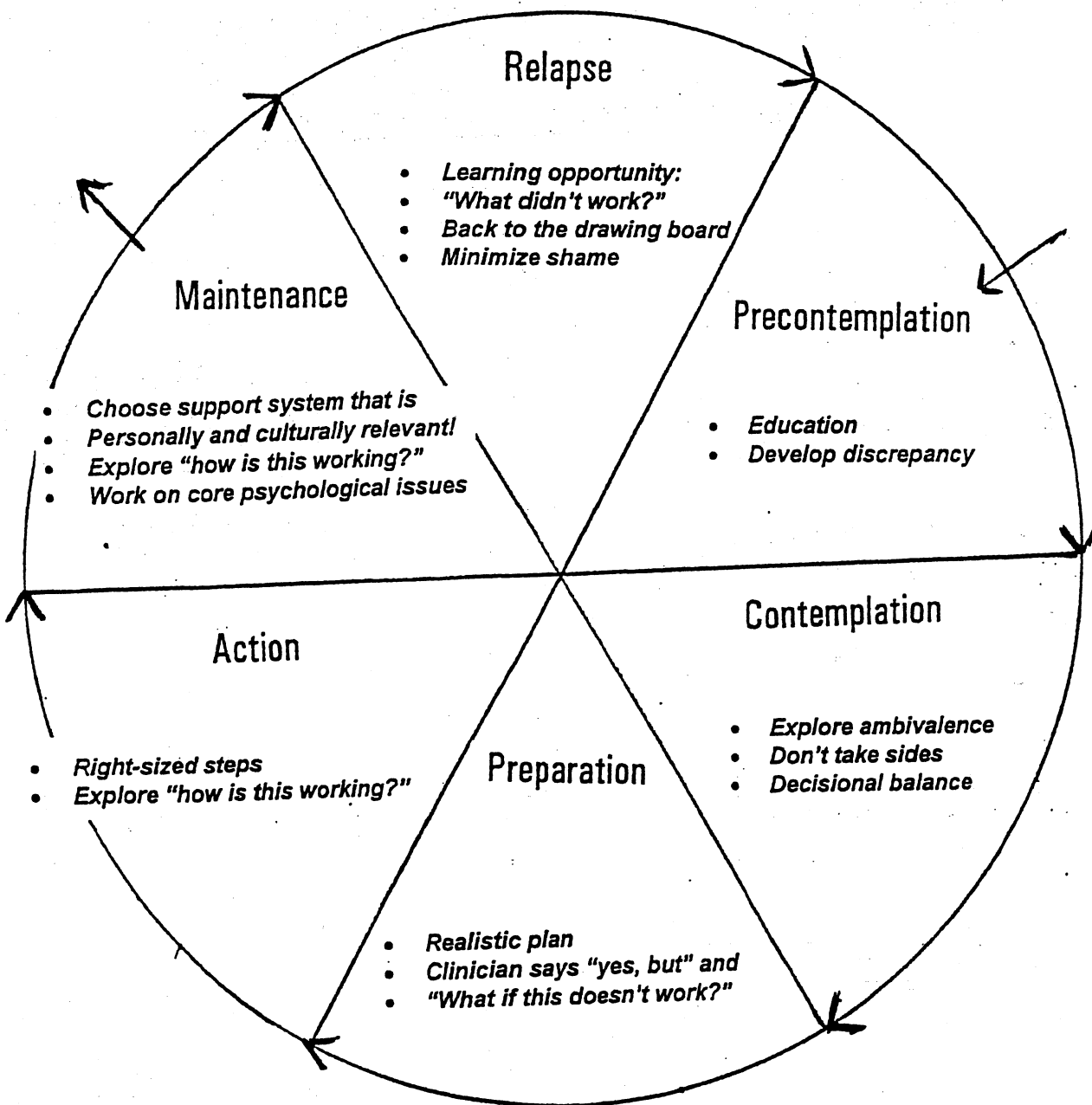
Early Strategies

1. Ask open-ended questions
2. Listen reflectively
3. Affirm
4. Summarize
5. Elicit Self Motivational Statements

Tactics to Elicit Self Motivational Statements

1. Evocative Questions
2. Decisional Balance
3. Elaborations
4. Using Extremes
5. Exploring Goals
6. Paradox

Stage Model of Change*



*Prochaska, James O., DiClemente, Carlo C., Norcross, John C. 1992. In Search of How People Change. *American Psychologist*. Vol.47(9): 1102-14.